Public Health Agency of Canada

2013–14

Departmental Performance Report

The Honourable Rona Ambrose, P.C., M.P.
Minister of Health

TO PROMOTE AND PROTECT THE HEALTH OF CANADIANS THROUGH LEADERSHIP, PARTNERSHIP, INNOVATION AND ACTION IN PUBLIC HEALTH.

— Public Health Agency of Canada

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Foreword

Departmental Performance Reports are part of the Estimates family of documents. Estimates documents support appropriation acts, which specify the amounts and broad purposes for which funds can be spent by the government. The Estimates document family has three parts.

Part I (Government Expenditure Plan) provides an overview of federal spending.

Part II (Main Estimates) lists the financial resources required by individual departments, agencies and Crown corporations for the upcoming fiscal year.

Part III (Departmental Expenditure Plans) consists of two documents. Reports on Plans and Priorities (RPPs) are expenditure plans for each appropriated department and agency (excluding Crown corporations). They describe departmental priorities, strategic outcomes, programs, expected results and associated resource requirements, covering a three-year period beginning with the year indicated in the title of the report. Departmental Performance Reports (DPRs) are individual department and agency accounts of actual performance, for the most recently completed fiscal year, against the plans, priorities and expected results set out in their respective RPPs. DPRs inform parliamentarians and Canadians of the results achieved by government organizations for Canadians.

Additionally, Supplementary Estimates documents present information on spending requirements that were either not sufficiently developed in time for inclusion in the Main Estimates or were subsequently refined to account for developments in particular programs and services.

The financial information in DPRs is drawn directly from authorities presented in the Main Estimates and the planned spending information in RPPs. The financial information in DPRs is also consistent with information in the Public Accounts of Canada. The Public Accounts of Canada include the Government of Canada Consolidated Statement of Financial Position, the Consolidated Statement of Operations and Accumulated Deficit, the Consolidated Statement of Change in Net Debt, and the Consolidated Statement of Cash Flow, as well as details of financial operations segregated by ministerial portfolio for a given fiscal year. For the DPR, two types of financial information are drawn from the Public Accounts of Canada: authorities available for use by an appropriated organization for the fiscal year, and authorities used for that same fiscal year. The latter corresponds to actual spending as presented in the DPR.

The Treasury Board *Policy on Management, Resources and Results Structures* further strengthens the alignment of the performance information presented in DPRs, other Estimates documents and the Public Accounts of Canada. The policy establishes the Program Alignment Architecture of appropriated organizations as the structure against which financial and non-financial performance information is provided for Estimates and parliamentary reporting. The same reporting structure

applies irrespective of whether the organization is reporting in the Main Estimates, the RPP, the DPR or the Public Accounts of Canada.

A number of changes have been made to DPRs for 2013–14 to better support decisions on appropriations. Where applicable, DPRs now provide financial, human resources and performance information in Section II at the lowest level of the organization's Program Alignment Architecture.

In addition, the format and terminology of the DPR have been revised to provide greater clarity, consistency and a strengthened emphasis on Estimates and Public Accounts information. As well, departmental reporting on the Federal Sustainable Development Strategy has been consolidated into a new supplementary information table posted on departmental websites. This new table brings together all of the components of the Departmental Sustainable Development Strategy formerly presented in DPRs and on departmental websites, including reporting on the Greening of Government Operations and Strategic Environmental Assessments. Section III of the report provides a link to the new table on the organization's website. Finally, definitions of terminology are now provided in an appendix.

Minister's Message

I am pleased to present the Public Health Agency of Canada's 2013–14 Departmental Performance Report. This report highlights the Agency's continued commitment to promote and protect the health of Canadians through leadership, partnership, innovation, and action in public health.

In 2013–14, the Agency strengthened emergency preparedness and response capacity by enhancing border health security, and taking steps to ensure safer laboratory use of pathogens and toxins. In collaboration with provincial and territorial partners, the Agency continued to undertake surveillance on diseases of highest risk to Canadians.

To support Canadians in improving their health and reducing their risks for chronic disease or injury, the Agency established new partnerships and funded projects that support child, youth and family mental health, wellness, and healthy living. The Play Exchange was launched at the 2014 Sochi Winter Olympic Games in partnership with the Canadian Tire Corporation, the Canadian Broadcasting Corporation, and LIFT Philanthropy Partners to involve Canadians in developing ways to promote healthy living across Canada. As a public health priority, the Agency initiated work with the health sector to equip health professionals with the information they need to support Canadians who are experiencing family violence.

To strengthen Canada's public health infrastructure, the Agency officially opened the JC Wilt Infectious Diseases Research Centre in Winnipeg in 2014. This facility expands and advances Canada's capacity to counteract a range of infectious diseases. In support of global public health, the Agency also deployed mobile laboratories to assist international partners in responding to outbreaks to help save lives.

These are only a few of the Agency's successes over the past year. As Minister of Health, I am very satisfied with the Agency's accomplishments in 2013–14. The Agency continues to be a leader and effective partner in achieving a vision of healthy Canadians and communities in a healthier world.

The Honourable Rona Ambrose, P.C., M.P.
Minister of Health

Section I: Organizational Overview

Organizational Profile

Minister: The Honourable Rona Ambrose, P.C., M.P.

Institutional Head: Krista Outhwaite, Acting Deputy Head

Ministerial Portfolio: Health

Enabling Instruments: *Public Health Agency of Canada Act*,[i] *Department of Health Act*,[ii] *Emergency Management Act*,[iii] *Quarantine Act*,[iv] *Human Pathogens and Toxins Act*,[v] *Health of Animals Act*,[vi] and the *International Health Regulations*.[vii]

Year of Incorporation / Commencement: 2004

Other: In June 2012, the Deputy Heads of Health Canada and the Public Health Agency of Canada signed a Shared Services Partnership Framework Agreement. Under this agreement, each organization retains responsibility for a different set of internal services and corporate functions. These include human resources, real property, information management / information technology, security, internal financial services, communications, emergency management, international affairs, internal audit services, and evaluation services.

The Canadian Food Inspection Agency joined the Health Portfolio in October 2013.

Organizational Context

Raison d'être

Public health involves the organized efforts of society to keep people healthy and to prevent injury, illness and premature death. The Public Health Agency of Canada[viii] (the Agency) has put in place programs, services and policies that protect and promote the health of all Canadians which form part of "public health". In Canada, public health is a responsibility that is shared by all three levels of government in collaboration with the private sector, non-governmental organizations, health professionals and the public.

In September 2004, the Agency was created within the federal Health Portfolio[ix] to deliver on the Government of Canada's commitment to increase its focus on public health in order to help protect and improve the health and safety of all Canadians and to contribute to strengthening the health care system.

Responsibilities

The Agency has the responsibility to:

- Contribute to the prevention of disease and injury, and to the promotion of health;
- Enhance the quality and quantity of surveillance data and expand the knowledge of disease and injury in Canada;
- Provide federal leadership and accountability in managing national public health events/emergencies;
- Strengthen intergovernmental collaboration on public health and facilitate national approaches to public health policy and planning; and
- Serve as a central point for sharing Canada's public health expertise with international partners, and to translate international knowledge and approaches to inform and support Canada's public health priorities and programs—for example, by participating in international working groups to develop new public health tools to protect, mitigate, and respond to emerging public health threats.

Strategic Outcome(s) and Program Alignment Architecture (PAA)

For the purposes of this Departmental Performance Report, the Agency is using the 2014–15 Management, Resources and Results Structure (MRRS). This will permit a more accurate performance story and enable better alignment with the 2013-14 Report on Plans and Priorities.

1 **Strategic Outcome:** Protecting Canadians and empowering them to improve their health
- **1.1 Program:** Public Health Infrastructure
  - **1.1.1 Sub-Program:** Public Health Capacity Building
  - **1.1.2 Sub-Program:** Public Health Information and Networks
  - **1.1.3 Sub-Program:** Public Health Laboratory Systems
- **1.2 Program:** Health Promotion and Disease Prevention
  - **1.2.1 Sub-Program:** Infectious Disease Prevention and Control
    - **1.2.1.1 Sub-Sub-Program:** Immunization
    - **1.2.1.2 Sub-Sub-Program:** Infectious and Communicable Disease
    - **1.2.1.3 Sub-Sub-Program:** Food-borne, Environmental and Zoonotic Infectious Disease
  - **1.2.2 Sub-Program:** Conditions for Healthy Living
    - **1.2.2.1 Sub-Sub-Program:** Healthy Child Development
    - **1.2.2.2 Sub-Sub-Program:** Healthy Communities
  - **1.2.3 Sub-Program:** Chronic (non-communicable) Disease and Injury Prevention
- **1.3 Program:** Health Security
  - **1.3.1 Sub-Program:** Emergency Preparedness and Response
  - **1.3.2 Sub-Program:** Border Health Security
  - **1.3.3 Sub-Program:** Biosecurity

Internal Services

Organizational Priorities

Organizational Priorities

Priority	Type[1]	Programs
1. Strengthened public health capacity and science leadership	Previously committed to	1.1, 1.2, 1.3

Summary of Progress

Why is this a priority?

The Agency provides national leadership to strengthen public health and science to support effective decision making, public health practices and interventions, and an integrated, evidence-based public health system.

What progress has been made toward this priority?

The Agency enhanced the capacity of the Canadian public health workforce by placing public health officers (PHOs) and field epidemiologists across Canada. PHOs are located where there are identified public health capacity gaps, especially in the North, to support provinces and territories (P/Ts) as well as regional health authorities for a period of two years.

The Agency established an office in Iqaluit and a Northern Unit in Whitehorse to strengthen the Agency's presence in the North.

Through the Canadian Best Practices Portal[x] and the Chronic Diseases and Injuries in Canada[xi] journal, the Agency increased public health professionals' access to information and best practices in the areas of oral health, seniors' health, mental health, violence prevention, child and maternal health, injuries and injury prevention. The majority of key stakeholders (92%) agreed that the journal contributed to increasing their knowledge related to chronic diseases and injuries.

The Agency provided a two-week bioinformatics workshop to public health partners on working with and analyzing "big data".[2] Providing training to national public health partners in this highly-specialized and rapidly-evolving field builds national capacity and strengthens Canada's role as a global leader in next-generation sequencing technologies and interpretation.

Priority	Type	Programs
2. Leadership on health promotion and disease prevention	Previously committed to	1.1, 1.2

Summary of Progress

Why is this a priority?

The Agency provides leadership and takes action to address the burden of illness associated with common risk factors, multiple chronic and communicable diseases and an aging population, as well as

[1] Type is defined as follows: **previously committed to**—committed to in the first or second fiscal year prior to the subject year of the report; **ongoing**—committed to at least three fiscal years prior to the subject year of the report; and **new**—newly committed to in the reporting year of the RPP or DPR. If another type that is specific to the department is introduced, an explanation of its meaning must be provided.

[2] Big data refers to large and complex data sets (e.g., microbial whole-genome sequence data) that are difficult to manipulate or process using standard data processing applications and tools.

the social, economic and environmental conditions that affect Canadians' health status and can increase the potential for disease occurrence. By providing a stronger evidence base on important health issues and their determinants, the Agency works to improve population health and well-being and reduce health inequalities.

What progress has been made toward this priority?

The Agency supported health promotion and chronic and communicable disease prevention programs and initiatives that addressed the mental, social, and physical factors affecting the health of Canadians, particularly vulnerable and at-risk populations.[3]

The Agency also supported initiatives such as "Lifestyle Prescriptions" to help rural Canadians reduce their risk of Type II diabetes, and the Breast Health Program in Ontario to help women understand their risk factors. This past year, the National Automated External Defibrillator Program[xii] installed 484 defribillators in recreational facilities across Canada to increase the chance of survival from sudden cardiac arrests. Within a short timeframe, one life was saved as a result of this initiative.

In addition, the Agency partnered with the private, charitable, and not-for profit sectors to support interventions aimed at the common risk factors (physical inactivity, unhealthy eating, and tobacco use) that contribute to major chronic diseases.

The Agency launched a renewed *Canada Communicable Disease Report* (CCDR) that integrates surveillance data, disease trends and outbreak information. The revised CCDR has been welcomed by P/Ts as an important component of collaboration among public health stakeholders.

The Agency disseminated evidence-based surveillance, guidance, and information products including: Questions and Answers: Inclusive Practice in Prevention of Sexually Transmitted Blood-borne Infections (STBBIs) Among Ethnocultural Minorities;[xiii] and the Population Specific Report on HIV/AIDS and other STBBI among youth in Canada.[xiv]

The Agency also began implementing integrated approaches to HIV and related STBBIs including engaging stakeholders in the development of a new HIV/AIDS and Hepatitis C Action Fund (to be established by April 2017) and began discussions to expand the mandate of the ministerial advisory council.

Priority	Type	Programs
3. Enhanced Public Health Security	Previously committed to	1.1, 1.2, 1.3
Summary of Progress		

Why is this a priority?

All governments must continue to collaborate to protect the health and safety of Canadians within a context of globalization, environmental change and scientific discovery. The Agency plays an important role supporting public health security through emergency preparedness and response, border health security, and biosecurity.

[3] This support included: the Community Action Program for Children,[xv] the Canada Prenatal Nutrition Program,[xvi] the Aboriginal Head Start in Urban and Northern Communities,[xvii] program, the Fetal Alcohol Spectrum Disorder Initiative,[xviii] the Innovation Strategy,[xix] Multi-Sectoral Partnerships to Promote Healthy Living and Prevent Chronic Disease,[xx] the Federal Initiative to Address HIV/AIDS in Canada, and the Canadian HIV Vaccine Initiative.[xxi]

What progress has been made toward this priority?

The Agency strengthened emergency preparedness and response capacity through the adoption of a risk and evidence-based approach to managing the National Emergency Strategic Stockpile. In addition, the Public Health Network (PHN) finalized and endorsed the federal, provincial, territorial (F/P/T) *Operational Framework for Mutual Aid Requests* (OFMAR). The OFMAR provides a consistent and timely pan-Canadian approach to the request, offer, and receipt of resources during public health events/emergencies.

The integration of the Agency's Quarantine Program with Health Canada's (HC) Travelling Public Program helped the Agency create a stronger link with domestic and international partners to enhance border health security and to prevent the introduction and spread of communicable diseases.

The *Pathogen Oversight Framework for Canada* was enhanced through the Agency's development of risk-based regulations to support the complete implementation of the *Human Pathogens and Toxins Act* (HPTA). Once implemented, Canada's national program will extend beyond existing import-based controls to include biosafety and biosecurity requirements for domestically-acquired and/or produced human pathogens and toxins.

Priority	Type	Program
4. Excellence and innovation in management	Previously committed to	Internal Services

Summary of Progress

Why is this a priority?

Effective management, engagement, collaboration, teamwork and professional development are all essential to a high-performing organization that achieves its intended outcomes. Recognizing this, the Agency is committed to a rigorous pursuit of excellence, innovation and continuous improvement in the design and delivery of programs and services.

What progress has been made toward this priority?

Through the Shared Services Partnership (SSP), the Agency and HC continued to strengthen the delivery of shared services by:

- harmonizing and aligning policies such as the Real Property Management Framework;
- streamlining human resource corporate support and processes through an ongoing review of the Common Human Resources Policy Suite; and
- completing the Common Human Resources (HR) Business Process project in support of the integration of an HR Service Delivery Model with streamlined and standardized HR processes.

The Agency participated in the first-ever Canadian Open Data Event in order to share public health information and encourage new and practical applications in support of the Agency's operations and program delivery. In addition, the Agency developed innovative ways to share snapshots of key chronic disease and injury information with Canadians by producing the Chronic Disease Indicator Framework, data cubes and an infographic on healthy weights.

As well, advances were made by the SSP on government-wide, IT-modernization initiatives such as:

- transitioning to the new government-wide e-mail;
- migrating from a landline phone system to cellular use; and
- responding to Web mail from Canadians in a more timely manner.

Risk Analysis

Key Risks

Risk	Risk Response Strategy	Link to PAA
Public Health Infrastructure	In order to plan for, detect, and respond to public health threats, Canada must have an effective public health infrastructure (i.e., workforce, capability, and inter-jurisdictional systems). To help mitigate the risk of gaps in this area, the Agency: • contributed to the development of a trained public health workforce through the placement of field epidemiologists and public health officers across Canada; • trained and mobilized staff to assist in the management of public health events domestically and internationally; • collaborated with F/P/T partners to develop policies, guidelines, processes, and tools to appropriately acquire, manage, and share public health information; and • identified lessons learned from reviews of emergency preparedness exercises and the response to public health events such as H7N9 and Middle East respiratory syndrome coronavirus (MERS-CoV) to help the Agency to better manage risk when responding to emerging public health events.	1.1, 1.2, 1.3
Infectious Disease Prevention and Control	To mitigate the risks associated with infectious disease prevention and control, the Agency: • developed regulations and enhanced the Biosecurity Program to mitigate the risk of intentional and unintentional misuse of pathogens in Canadian laboratories; • conducted public health research and surveillance, advanced laboratory science, and performed reference laboratory services, including outbreak-response capacity for partners by leveraging highly-specialized expertise and state-of-the-art technologies, including genomics; • provided leadership on public health planning through the work of the Pan-Canadian Public Health Network Communicable and Infectious Disease Steering Committee; • provided leadership and expert advice to federal partners and to P/T partners and stakeholders on surveillance, laboratory science and disease guidance; • supported safe and effective vaccine use. The Agency leveraged the expert advice of the National Advisory Committee on Immunization[xxii] (an external advisory body) to help facilitate vaccine uptake across Canadian jurisdictions. Vaccine uptake was also enabled through the development of tools such as a mobile application to assist families in managing their vaccinations; • informed evidence-based frameworks, strategies, and interventions by translating knowledge generated through surveillance, science, and research on infectious diseases and communicating it to partners and other public health stakeholders; • developed risk-based targeted prevention and control initiatives for key emerging and re-emerging infectious diseases and trends, including food-borne illnesses, vector-borne diseases, pandemics, and antimicrobial resistance;	1.1, 1.2, 1.3

	• developed and implemented the Tuberculosis Prevention and Control: Federal Framework for Action,[xxiii] and the National Immunization Strategy[xxiv] in collaboration with P/T partners; and • responded to outbreaks of infectious diseases, including measles in British Columbia, Alberta, Saskatchewan, and Ontario as well as tuberculosis in the North, in collaboration with multi-jurisdictional partners.	
Conditions for Healthy Living	To address issues of healthy living and healthy weights in targeted populations, the Agency: • continued the implementation of the Multi-Sectoral Partnership Approach to Promote Healthy Living and Prevent Chronic Disease[xxv] to address risk factors such as physical inactivity, unhealthy eating, and tobacco use that underlie major chronic diseases; • contributed to a broader understanding of how to achieve healthier weights and reduce barriers by addressing underlying environmental, social, demographic, and economic issues through projects funded by the Innovation Strategy: Achieving Healthier Weights in Canada's Communities;[4,xxvi]; and • reported on the Progress on Advancing the F/P/T Framework on Healthy Weights,[xxvii] which details the most recent national data on factors associated with childhood obesity and healthy weights. Working with various levels of government and the Mental Health Commission of Canada to reduce gaps in mental health knowledge and develop tools for use by public health professionals, the Agency: • contributed to and endorsed the World Health Organization's Comprehensive Mental Health Action Plan at the sixty-sixth session of the World Health Assembly;[xxviii] • consulted P/Ts, NGOs and other government departments to inform the development of the *Federal Framework on Suicide Prevention*, which, when completed, is expected to guide Government of Canada efforts and serve as a tool to provide Canadians with reliable and credible information on suicide and its prevention; • initiated a positive mental health indicator framework to enable data collection on protective factors such as resilience, social support, and physical environments; • continued to conduct mental illness, suicide, and child maltreatment surveillance; and • provided guideline-development expertise, research advice, and support to the Canadian Task Force on Preventive Health Care[xxix] to develop a screening guideline[xxx] to help primary care practitioners screen for depression in adults. To leverage its existing programs and public health expertise for vulnerable populations, the Agency continued partnering or collaborating with: • HC on developing the *Aboriginal Ways Tried and True Framework for the Canadian Best Practices Portal* to identify evidence-based information on "what works" within a culturally-appropriate context for First Nations, Métis, and Inuit traditional understanding of health;	1.2

[4] Funded projects focused on food security; school and family-based approaches; supportive physical and social environments; and northern community-based initiatives targeting children, youth, and families across the life span.

	• Aboriginal Affairs and Northern Development Canada, Aboriginal organizations and communities in addressing health inequity issues among aboriginal off-reserve populations, as part of the Urban Aboriginal Strategy;[xxxi] and • HC and the Government of Nunavut on a project to reduce the severity and prevalence of dental issues in children by increasing early intervention and screening of Nunavut children from birth to age seven (5,800 eligible children).	
Excellence and innovation in management	The Agency actively promoted innovation in program delivery and improvements in business practices and operations through the ongoing implementation of an SSP approach with HC. Thirty-six initiatives were completed in support of Blueprint 2020, including: • streamlining procurement, travel, and hospitality processes; • optimizing office space in compliance with Workplace 2.0 standards; and • restructuring and transforming regional office programs and functions to improve efficiency and relevance.	Internal Services

Risk Narrative

The Agency operates within a dynamic and complex environment where domestic and international public health challenges continually evolve, highlighting the importance of ongoing planning and preparedness for public health events/emergencies. The multi-jurisdictional nature of public health also means that the Agency must work closely with domestic and international partners to respond to situations and to build on lessons learned.

The risks[5] identified in the table above were drawn from the Agency's 2012–13 Corporate Risk Profile. These risks were ranked as having the highest likelihood of significant impacts on the achievement of the Agency's objectives, and the most significant potential health and safety consequences for Canadians in the event of a failure of any risk response strategy.

Actual Expenditures

Budgetary Financial Resources (dollars)

2013–14 Main Estimates	2013–14 Planned Spending	2013–14 Total Authorities Available for Use	2013–14 Actual Spending (authorities used)	Difference (actual minus planned)
579,236,460	586,646,596	641,127,126	621,497,636	34,851,040

[5] The Agency's approach to integrated risk management is consistent with: ISO 31000 Risk Management Principles and Guidelines,[xxxii] the Treasury Board of Secretariat's (TBS) Framework for the Management of Risk,[xxxiii] Guide to Corporate Risk Profiles,[xxxiv] Guide to Developing Risk Statements,[xxxv] Guide to Risk Taxonomies,[xxxvi] Risk Management Capability Model,[xxxvii] Guide to Integrated Risk Management,[xxxviii] the Agency's IRM Policy and IRM Standard, and the International Risk Governance Council's Workshop Report: Public Sector Governance of Emerging Risks Hallmarks and Drivers, May 2013.[xxxix]

Planned Spending was higher than Main Estimates due to the receipt of in-year funding to continue enhancing the ability to prevent, detect and respond to food-borne illness outbreaks, and funding to streamline government import regulations and border processes for commercial trade.

Total Authorities were higher than Planned Spending primarily due to the inclusion of additional authorities for the operating budget carry forward; statutory items; reimbursement of paylist expenditures; payments required by collective agreements; funding received from HC for the Travelling Public Program; and funding re-profiled from previous fiscal years for the pandemic vaccine fill line project as well as the National Antiviral Stockpile (NAS).

Actual Spending was less than Total Authorities mainly due to lower P/T orders of vaccines for the NAS; expenditure reductions achieved through streamlined administration, travel, and; professional services; as well as administrative efficiencies in delivering grants and contributions programs.

Human Resources (Full-Time Equivalents — FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
2,521	2,106	(415)

The variance is primarily due to the transfer of various programs to HC as part of the Health Portfolio Shared Services Partnership which resulted in the consolidation and streamlining of internal services organizations to create efficiencies.

Budgetary Performance Summary for Strategic Outcome and Programs (dollars)

Strategic Outcome: Protecting Canadians and empowering them to improve their health

Programs and Internal Services	2013–14 Main Estimates	2013–14 Planned Spending	2014–15 Planned Spending	2015–16 Planned Spending	2013–14 Total Authorities Available for Use	2013–14 Actual Spending (authorities used)	2012–13 Actual Spending (authorities used)	2011–12 Actual Spending (authorities used)
1.1 Public Health Infrastructure	133,112,689	135,094,390	118,150,146	118,150,147	135,026,327	132,987,799	137,453,765	142,095,118
1.2 Health Promotion and Disease Prevention	308,201,823	311,655,696	350,697,145	295,772,937	313,869,611	305,929,930	315,767,073	330,048,738
1.3 Health Security	47,709,580	48,954,953	55,329,126	54,896,463	77,673,470	73,097,007	59,951,642	45,237,627
Subtotal	489,024,092	495,705,039	524,176,417	468,819,547	526,569,408	512,014,736	513,172,480	517,381,483
Internal Services Subtotal	90,212,368	90,941,557	90,520,268	90,067,773	114,557,718	109,482,900	106,483,749	119,118,054
Total	579,236,460	586,646,596	614,696,685	558,887,320	641,127,126	621,497,636	619,656,229	636,499,537

Planned Spending will increase in 2014–15 and subsequently decrease in 2015–16 as the Agency makes the final payment of $49.7M under the Hepatitis C Health Care Services Program.

Alignment of Spending With the Whole-of-Government Framework

Alignment of 2013–14 Actual Spending With the Whole-of-Government-Framework Spending Area[XL] (dollars)

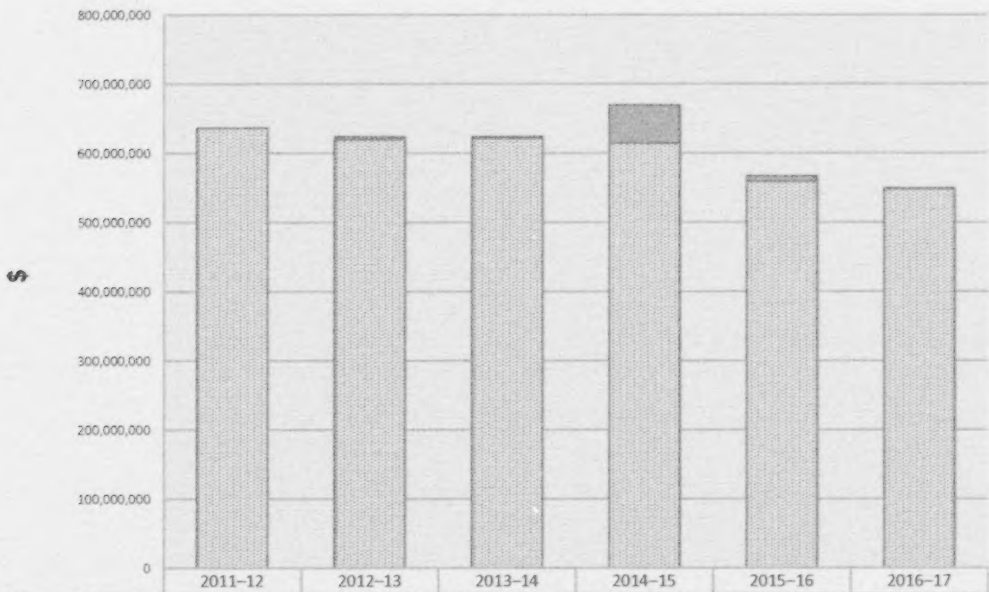
Strategic Outcome	Program	Spending Area	Government of Canada Outcome	2013–14 Actual Spending
Protecting Canadians and empowering them to improve their health	1.1 Public Health Infrastructure	Social Affairs	Healthy Canadians	132,987,799
	1.2 Health Promotion and Disease Prevention	Social Affairs	Healthy Canadians	305,929,930
	1.3 Health Security	Social Affairs	A Safe and Secure Canada	73,097,007

Total Spending by Spending Area (dollars)

Spending Area	Total Planned Spending	Total Actual Spending
Economic Affairs	N/A	N/A
Social Affairs	495,705,039	512,014,736
International Affairs	N/A	N/A
Government Affairs	N/A	N/A

Departmental Spending Trend

Departmental Spending Trend Graph



	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17
Sunset Programs	0	4,000,000	2,170,132	54,558,287	7,853,866	1,040,100
Total Spending	636,499,537	619,656,229	621,497,636	614,696,685	558,887,320	547,646,932

The changes in spending are associated primarily with: issuing the final payment for the Hepatitis C Health Care Services Program in 2014–15; sunsetting of some temporary Agency programs; and continued savings measures achieved through streamlined administration, travel, and professional services, as well as administrative efficiencies in delivering grants and contributions programs.

The Agency will continue to examine the level of resources required for priority initiatives and seek renewal as appropriate.

Estimates by Vote

For information on the Agency's Votes and statutory expenditures, consult the *Public Accounts of Canada 2014* [xli] on the Public Works and Government Services Canada website.

Section II: Analysis of Programs by Strategic Outcome

Strategic Outcome: *Protecting Canadians and empowering them to improve their health*

The Agency's strategic outcome is *Protecting Canadians and empowering them to improve their health*. How long Canadians live in good health is determined by factors including personal and family lifestyle risk factors, environmental and genetic factors, technological advances, social determinants, availability and quality of health care, and public health practices and initiatives at the federal, provincial, territorial (F/P/T), and local levels of government. The Agency works with governmental and non-governmental stakeholders to positively affect the factors of health listed above.

Program 1.1: *Public Health Infrastructure*

Description:

The Public Health Infrastructure Program strengthens Canada's public health workforce capability, information exchange, and F/P/T networks, and scientific capacity. These infrastructure elements are necessary to support effective public health practice and decision making in Canada. Working with federal, provincial and territorial stakeholders and within existing collaborative mechanisms, the Program supports planning for and building consensus on strategic and targeted investments in public health infrastructure, including training, tools, best practices, standards, and mechanisms to facilitate information exchange and coordinated action. Public health laboratories provide leadership in research, technical innovation, reference laboratory services; surveillance; outbreak response capacity; and national laboratory coordination. Through these capacity-building mechanisms and scientific expertise, the Government of Canada facilitates effective coordination and timely public health interventions which are essential to having an integrated and evidence-based national public health system. Key stakeholders include local, regional, provincial and national public health organizations, practitioners and policy makers, researchers and academics, professional associations and non-governmental organizations.

Budgetary Financial Resources (dollars)

2013–14 Main Estimates	2013–14 Planned Spending	2013–14 Total Authorities Available for Use	2013–14 Actual Spending (authorities used)	2013–14 Difference (actual minus planned)
133,112,689	135,094,390	135,026,327	132,987,799	(2,106,591)

Human Resources (Full-Time Equivalents [FTEs])

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
778	714	(64)

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Canada has the public health system infrastructure to manage public health threats of domestic and international concern	Level of Canada's compliance with the public health capacity requirements outlined in the *International Health Regulations (IHR)*	3 (by March 31, 2015)	2
Canada is able to use highly specialized laboratory technologies to identify and characterize pathogens in support of public health surveillance and investigation of disease outbreaks	The number of pathogens for which molecular typing is offered by national laboratories	128 (by March 31, 2015)	128

Performance Analysis and Lessons Learned

Canada continued to meet the core public health capacity requirements outlined in the *International Health Regulations* (IHR). The Agency's annual assessment to the World Health Organization (WHO) confirmed that Canada maintained strong capacity (level 2) and continued to work toward advanced capability (level 3).[6] The Agency also supported other countries in developing their core capacities to meet the IHR obligations.

The Agency continued to advance the use of leading-edge technologies for pathogen identification and characterization in support of infectious disease surveillance and investigation, enabling rapid detection and a more complete understanding of key pathogens that impact the health of Canadians. The Agency and provincial public health partners initiated enhanced national surveillance of invasive pneumococcal disease. At the national level, this system will

[6] Level 3 involves the generation of information, products, and tools that reflect models of best practices and standards that can be adopted or shared globally.

monitor changes resulting from the implementation of vaccine programs as well as changes in antimicrobial susceptibility of *Streptococcus pneumonia*.[7]

To support timely information sharing, *Salmonella* antimicrobial-susceptibility[8] data obtained through the Canadian Integrated Program for Antimicrobial Resistance Surveillance[XLII] were linked with data from the PulseNet[XLIII] system. This integration enables public health partners to rapidly link information on the antimicrobial resistance (AMR)[9] of *Salmonella* with food-borne outbreaks and support the identification of emerging AMR trends.

Molecular surveillance enabled the genetic fingerprinting of Canadian measles cases and was instrumental in tracking the origin of measles cases to inform public health decisions aimed at preventing the sustained re-introduction of measles in Canada.

Sub-Program 1.1.1: *Public Health Capacity Building*

Description:

The Public Health Capacity Program contributes to the development and maintenance of a Canadian public health workforce which has the depth and capability to respond to public health issues and requirements at any time. Working with federal, provincial and territorial partners and stakeholders, the Program provides training and support to public health professionals to support this group to carry out core functions and respond effectively and cooperatively to public health events. The Program takes a leadership role in: developing strategies for public health human resources; identifying core competencies required for public health workforce; offering training for public health practitioners to be able to carry out core public health functions; strengthening national capacity to quickly respond to disease outbreaks and public health events; and providing funding to academia to strengthen and advance research and innovative methods in public health. The Program uses funding from the following transfer payment: Public Health Scholarship and Capacity Building Initiative.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
16,477,688	13,718,952	(2,758,736)

Note: Actual Spending was less than Planned primarily due to changes in organizational structure and re-alignment of resources within the Agency according to needs and priorities. In addition, delays in staffing and completing contracting processes also contributed to the variance.

[7] *Streptococcus pneumonia* is the primary cause of community-acquired pneumonia and meningitis in children and the elderly.
[8] Antimicrobial susceptibility refers to the ability of a typical concentration of an antimicrobial agent (e.g., antibiotic) to reliably inhibit the growth of an isolated organism (e.g., *Salmonella*).
[9] AMR occurs when organisms change in such a way that the medications used to cure the infections they cause become less effective.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
100	92	(8)

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Public health partners have the competencies and capabilities to execute their public health functions	Percent of PHAC field staff who say that their competencies have improved	85 (by March 31, 2017)	89
	Percent of public health practitioners who took PHAC training who say they are better equipped to perform public health functions	80 (by March 31, 2015)	85
	Percent of public health host organizations who say that PHAC field staff contributed to their capacity to respond to public health events	83 (by March 31, 2015)	83

Performance Analysis and Lessons Learned

The Agency increased Canadian public health workforce capacity to respond to public health events through the placement of four field epidemiologists and 13 public health officers (PHOs) across Canada, including in the North. The PHOs engaged in site-led projects that enhanced the public health capacity within provinces/territories (P/Ts) and local public health regions. Projects include the development of Community Health Profiles with selected health indicators that describe community characteristics; determinants of health and health status of the population; and building local public health capacity for sexual health and assisting in the implementation of the *Nunavut Territorial Sexual Health Framework*.

The Agency's field staff improved their competencies through training and mobilization to assist in the management of public health events/emergencies domestically and internationally which, in turn, enhanced Canada's public health capacity. For example, the Agency responded to domestic requests for assistance from P/Ts for tuberculosis (TB) in the North and provided epidemiological support to the Global Outbreak Alert and Response Network[XLIV] in the public health response to Typhoon Haiyan in the Philippines. These requests helped the Agency to better understand the skills and competencies required when mobilizing public health professionals. As well, Public health practitioners enhanced their competencies by enrolling in nearly 2,500 modules of the Skills Online[XLV] continuing education program offered by the Agency. Feedback indicated that almost all learners acquired new knowledge that was applicable to their professional practice.

Sub-Program 1.1.2: *Public Health Information and Networks*

Description:

The Public Health Information and Networks Program facilitates federal, provincial, and territorial coordination and collaboration, and establishes core structures to facilitate access to accurate and reliable information, tools and models required by Canadian public health professionals to perform their public health duties effectively. Working with federal, provincial and territorial partners through the Public Health Network, the Program provides leadership by consulting and undertaking collaborative planning for public health strategies and addressing issues affecting the sharing of information for effective surveillance and action. The Program also invests in tools and processes to allow public health practice and core public health functions to be informed by evidence and applied knowledge; develops scenarios for population and public health research, and prepares models for economic analysis to support effective decision- making. The Program uses funding from the following transfer payments: Assessed Contribution to the Pan American Health Organization, National Collaborating Centres for Public Health, and Grants to eligible non-profit international organizations in support of their projects or programs on health.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
35,527,823	33,323,185	(2,204,638)

Note: Actual Spending was less than Planned due to the re-alignment of resources within the Agency according to needs and priorities. In addition, delays in staffing and completing contracting processes also contributed to the variance.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
66	61	(5)

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Mechanisms are in place to enable public health partners to work collaboratively to address existing and emerging public health infrastructure issues	Number of jurisdictions who sign the Multilateral Information Sharing Agreement on infectious diseases and public health events	4 (by December 31, 2014)	0[10]
Public health organizations are engaged and participate in collaborative networks and processes	Percent of collaborative initiatives/projects delivered and/or on track based on work plans by fiscal year	70 (by March 31, 2015)	70
Public health professionals and partners have access to reliable, actionable public health data and information	Percent of public health professionals and partners who responded that the Chief Public Health Officer's (CPHO) Report on the State of Public Health in Canada was useful	75 (by March 31, 2015)	96

Performance Analysis and Lessons Learned

Working with F/P/T partners through the Public Health Network (PHN), the Agency developed policies, guidelines, processes, and tools to enable public health professionals to acquire, manage and share public health information.

The PHN Council met its target of having 70% of its collaborative initiatives/projects delivered and/or on track by fiscal year end, including the Second Biennial Healthy Weights Report to Ministers.

The Agency produced the CPHO's Report on the State of Public Health in Canada–2013[XLVI] which explored how infectious diseases can influence public health and the health status of Canadians. The Report shed light on Canada's successes and ongoing challenges in the prevention, control and management of infectious diseases. An online survey indicated that 96% of respondents found the Report to be informative and 70% of respondents have used (or intend to use) the content of the Report to inform or influence their professional work, personal interests, or opinions.

[10] Formal review by each jurisdiction was completed by March 31, 2014. In accordance with advice provided by the Council of Deputy Ministers of Health at their May 2014 meeting, the *Multilateral Information Sharing Agreement* is expected to be brought forward for signature by all F/P/T jurisdictions at the fall 2014 Health Ministers' Meeting.

Sub-Program 1.1.3: *Public Health Laboratory Systems*

Description:

The Public Health Laboratory Systems Program is a national resource providing Canada with a wide range of highly specialized scientific and laboratory expertise and access to state of the art technologies. The Program informs public health professionals at all levels of government to enable evidence-based decision making in the management of and response to diseases and their risk factors. The Program conducts public health research; uses innovative approaches to advance laboratory science; performs reference laboratory services; contributes to public health surveillance; provides outbreak response capacity; and leads national public health laboratory coordination. The Program also addresses public health risk factors arising from human, animal and environmental interactions by conducting research, surveillance and population risk analysis. These combined efforts work to inform infectious and chronic disease-specific strategies and prevention initiatives. The knowledge generated and translated by the Program supports the development and implementation of national and international public health policies, guidelines, interventions, decisions and action that contribute to the lifelong health of the population.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
83,088,879	85,945,662	2,856,783

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
612	561	(51)

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Decisions and interventions to protect the health of Canadians are supported by research and reference/testing services	Percent of accredited reference laboratory tests that are conducted within the specific turnaround times	95 (by March 31, 2015)	95.3
	Percent of clients indicating overall satisfaction with laboratory reference services as "satisfied" or "very satisfied"	90 (by March 31, 2015)	100

	# of citations to Agency laboratory research publication to demonstrate knowledge transfer uptake	1,800 (by March 31, 2015)	1,921[11]

Performance Analysis and Lessons Learned

The Agency's laboratories continued to strengthen Canada's public health capacity by identifying and mitigating risks associated with infectious diseases, and providing the technical expertise to address public health needs.

In 2014, the Agency opened the JC Wilt Infectious Diseases Research Centre, a major milestone in the expansion of Canada's capacity to counteract a range of infectious diseases. The Centre serves as a hub for HIV/AIDS laboratory research in Canada and will play a key role in developing new approaches to combat antimicrobial resistant organisms and carry out early vaccine research.

The impact of climate change on the emergence and re-emergence[12] of key infectious diseases, including West Nile virus and Lyme disease, was examined through Agency participation in collaborative studies with key partners to identify the populations most vulnerable to infectious diseases linked to climate change.

The Agency continued to play an important role in developing and improving approaches for the detection of diseases. For example, an improved diagnostic test was developed to detect disease-causing pathogens carried by certain ticks that will inform patient treatment. Using genomic[13] technologies, the Agency developed an improved method of tracking the sources of *Salmonella* Enteritidis – the cause of 40% of salmonellosis cases – that is being transferred to provincial public health laboratories to support outbreak response.

Through the hospital-based Canadian Nosocomial Infection Surveillance Program,[XLVII] Agency scientists were first in the world to identify an instance of *C. difficile*[XLVIII] that had reduced susceptibility to the primary antibiotic used as treatment (vancomycin) for which there are few alternatives. Agency scientists continue to work to identify why this reaction is occurring in order to develop a test for reduced susceptibility in other clinical samples and to help understand how diseases become drug-resistant.

The Agency continued to expand its molecular-based rapid identification of antibiotic resistance and this has meant that improved treatment strategies for TB patients are available faster and has enhanced detection of high-priority drug-resistant TB cases.

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[11] This Actual Result represents citations to Agency research papers published in the three-year period between 2011 and 2013.

[12] Emerging infectious diseases are those caused by newly-identified and previously unknown infectious agents that cause public health problems either locally or internationally. In contrast, re-emerging infectious diseases involve infectious agents that have been known for some time, but which are showing upward trends in incidence or prevalence following a period of abatement to such a low level that they had not been considered a public health issue.

[13] Genomics refers to the study of genetic information (e.g., genes and other DNA, RNA products) in a living person or organism that is needed to maintain life.

Program 1.2: *Health Promotion and Disease Prevention*

Description:

The Health Promotion and Disease Prevention Program aims to promote better overall health of the population—with additional focus on those that are most vulnerable—by promoting healthy development among children, adults and seniors, reducing health inequalities, and preventing and controlling chronic and infectious diseases. Working in collaboration with provinces and territories, the Program develops and implements federal aspects of frameworks and strategies (e.g., *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights*, national approaches to addressing immunization, HIV/AIDS) geared toward promoting health and preventing disease. The Program carries out primary public health functions of health promotion, surveillance, science and research on diseases and associated risk and protective factors to inform evidenced-based frameworks, strategies, and interventions. It also undertakes health promotion and prevention initiatives working with stakeholders to prevent and mitigate chronic disease and injury, and to help prevent and control infectious disease.

Budgetary Financial Resources (dollars)

2013–14 Main Estimates	2013–14 Planned Spending	2013–14 Total Authorities Available for Use	2013–14 Actual Spending (authorities used)	2013–14 Difference (actual minus planned)
308,201,823	311,655,696	313,869,611	305,929,930	(5,725,766)

Note: Planned Spending was higher than Main Estimates due to the receipt of in-year funding through Supplementary Estimates for Listeriosis to continue enhancing the ability to prevent, detect and respond to food-borne illness outbreaks. Actual Spending was less than Planned due to a transfer of authorities to HC for Northern Wellness Approach. Delays in staffing and in completing contracting processes also contributed to the variance.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
897	850	(47)

Performance Results

Expected Results	Performance Indicators	Targets[14]	Actual Results[15]
Diseases in Canada are prevented or mitigated	Rates per 100,000 of key infectious diseases (HIV)	6.41	5.9 (2012)
	Rates per 100,000 of key infectious diseases (hepatitis B)	9.17	9.4 (2012)
	Rates per 100,000 of key infectious diseases (hepatitis C)	28.82	29.32 (2012)
	Rates per 100,000 of key infectious diseases (tuberculosis)	3.6	4.8 (2012)
	Rates per 100,000 of key infectious diseases (*E. coli* 0157)	1.39	1.34 (2013)
	Rates per 100,000 of key infectious diseases (salmonella)	19.68	17.83 (2013)
	Rates per 100,000 of key infectious diseases (invasive pneumococcal disease in children of less than one year old)	28	18.05 (2012)
	Rates per 100,000 of key infectious diseases (invasive pneumococcal disease in children ages one to four years)	20	13.57 (2012)
	Rates per 100,000 of key infectious diseases (pertussis deaths in the target population of less than or equal to three months of age)	0	3 (2012)[16]
	Rates per 100,000 of key infectious diseases (invasive meningococcal disease)	0.7	0.51 (2011)
	Rate of key chronic disease risk factors (% of adults aged 20 and over that report being physically active)	50.1[17]	51.9 (2013)
	Rate of key chronic disease risk factors (% of children and youth aged 5 to 17 who are overweight or obese)	31.5[18]	31.5 (2009–11)

Performance Analysis and Lessons Learned

The Agency continued to foster partnerships with P/Ts and public and private sector organizations by investing nearly $20M in multi-sectoral partnership projects[XLIX] to address healthy living (physical activity, healthy weights, tobacco cessation/prevention) and chronic

[14] To be achieved by March 31, 2015.
[15] These results were obtained through national and/or Pan-Canadian surveillance and survey approaches. Where cycles provide for new information, the Actual Results will be updated along with the latest year of data availability.
[16] These preliminary data include all deaths from pertussis, but the majority of pertussis deaths are among infants less than two months of age.
[17] This baseline was obtained through the *Canadian Community Health Survey* (2009–10). Over time, the objective is to achieve an upward trend for physical activity.
[18] This baseline was obtained through the *Canadian Health Measures Survey* (2009–11). Over time, the objective is to achieve a downward trend for obesity and overweight.

disease prevention (diabetes, cancer, cardiovascular disease). The Agency broadened the scope of its partnerships to include the sports, entertainment, and retail sectors, as well as private foundations, to fund eight new initiatives, including: Play for Diabetes Prevention,[L] which employs sport and play-based tools to promote education and awareness for diabetes prevention among urban Aboriginal youth; and Active Start and FUNdamentals Program,[LI] which promotes physical activity and healthy eating to children between the ages of two and twelve with intellectual disabilities.

In addition, the Agency partnered with the Canadian Tire Corporation, LIFT Philanthropy Partners,[LII] and the Canadian Broadcasting Corporation (CBC) on The Play Exchange,[LIII] which was launched during the Sochi Winter Olympic Games.[LIV] This "first-of-its-kind" partnership received 418 submissions from Canadians on developing innovations to increase physical activity. The six finalists will receive national visibility in a CBC television special in 2015.

The Agency worked with stakeholders to develop targeted information to decrease the prevalence of key emerging and re-emerging infectious diseases. Current surveillance data demonstrate that most disease rates are close to or below targets; only the rate of TB exceeded the target. Although the incidence of active TB in the overall population continues to gradually decline,[19] higher rates persist among Aboriginal peoples and foreign-born individuals. Focused research, prevention, and control activities were undertaken to inform P/T action to address this ongoing challenge.[20]

The Evaluation of the Federal Initiative to Address HIV/AIDS in Canada (2008–09 to 2012–13)[LV] found that the Agency and its partners have made solid progress on addressing HIV/AIDS and that the initiative continued to be relevant and aligned with priorities in disease prevention. It recommended enhancements to joint planning, knowledge exchange, and application, and to activities to address barriers to prevention, diagnosis, care, treatment, and support. The Agency and its federal partners have begun the development of joint plans and other activities to address these findings.

Sub-Program 1.2.1: *Infectious Disease Prevention and Control*

Description:

The Infectious Disease Prevention and Control Program is the national focal point for efforts to help prevent, mitigate and control the spread and impact of infectious diseases in Canada. The Program provides leadership for integrating activities related to surveillance, laboratory science, epidemiology, research, promotion, modeling, intervention and prevention, including immunization. Applying an evidence-based approach, the Program informs targeted prevention and control initiatives for many infectious disease threats including acute respiratory and vaccine preventable infections (e.g., influenza, measles), sexually transmitted and blood borne infections

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[19] Over the past two decades, both the number and incidence rate of reported cases of active TB have continued to decline, albeit more gradually than the drop observed from 1950 to 1990. In 1992, the rate was 7.7 per 100,000 population, whereas in 2012, the rate was 4.8 per 100,000 population.

[20] See Sub-Sub-Program 1.2.1.2 for information on the *Federal Framework for Action*.

(e.g., hepatitis B and C, HIV), hospital associated infections (e.g., *C. difficile*), and human diseases resulting from environmental exposures to food, water, animals and other vectors (e.g., Listeria, *E.coli* O157, West Nile virus). This Program reinforces efforts to protect the health and well-being of Canada's population, reinforces efforts to reduce the economic burden of infectious disease and provides expert advice to federal, provincial and territorial partners and stakeholders. The knowledge generated and translated by this Program influences and enables the development and implementation of public health policies, guidelines, interventions and action—including those required to meet Canada's International Health Regulations obligations—and helps to guide the population in their decisions regarding their personal health and that of their families.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
50,119,037	53,684,581	3,565,544

Note: Actual Spending was higher than Planned primarily due to additional funding received from the operating budget carry forward.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
341	323	(18)

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
New emerging and re-emerging infectious disease trends are identified and responded to in a timely manner	Percent of operational plans developed within six months to address new emerging and re-emerging infectious disease trends for non-outbreak situations of potentially serious consequence	75 (by March 31, 2015)	100
Actively engage Canadians on infectious disease issues	Percent uptake of information via social media outreach mechanisms	0.6 (by March 31, 2015)	0.7

Performance Analysis and Lessons Learned

The Agency continued to target issues of highest risk, enhancing responsiveness to key emerging and re-emerging infectious diseases.

Lyme disease has been expanding its range in Canada as changes in climate create favourable conditions for ticks beyond the traditional boundaries of this vector. The Agency developed and implemented an Action Plan on Lyme Disease[LVI] to mitigate the associated risks. Through collaboration with partners and stakeholders, the Agency began educating Canadians about the disease and its rise in Canada. The Agency also provided crucial diagnostic guidance for front-line professionals through webinars and publications

Measles transmission is typically low within Canada due to the high rate of immunization, a result of Agency and partners' disease prevention and control efforts. In 2014, there was an increase in the incidence of measles in parts of British Columbia, Alberta, Saskatchewan, and Ontario. This was found to be largely related to travel to/from countries experiencing a high level of measles outbreaks and was limited to pockets of the population in which immunization coverage is less robust. Given the potential for severe complications, particularly among unvaccinated infants under one year of age, the Agency implemented a targeted awareness campaign that included public health notices and travel advisories. The interventions provided the Agency with an opportunity to reinforce the importance of the good immunization practices and robust vaccine safety regime that are central to its National Immunization Strategy.

Bacterial resistance to antibiotics continued to be a focus for the Agency. Leading-edge research into AMR in TB, *gonorrhoeae*, and food-borne bacteria, as well as surveillance of antibiotic use, is building a solid evidence base for the Agency to drive policy and decision-making, aimed at promoting the sustainability of effective antibiotics.

Sub-Sub-Program 1.2.1.1: *Immunization*

Description:

The Immunization Program reduces the burden of infectious disease and contributes to higher life expectancies for Canada's population and lower costs to the health care system by supporting vaccine accessibility in Canada. Under the framework of the *National Immunization Strategy*, the Immunization Program seeks to protect all of the population from vaccine preventable diseases by providing a science based approach for the use of existing and the introduction of new vaccines, encouraging maximum vaccine uptake and coverage, providing information on vaccine surveillance and safety, and ensuring a safe and affordable supply of vaccines. In this regard, the Program enables provinces and territories to access vaccines at a reduced cost through bulk purchases so a supply of vaccine is available in the event of an outbreak. The Program also supports the work of the National Advisory Committee on Immunization which provides expert advice on vaccine use for all jurisdictions in Canada.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
7,711,502	8,373,985	662,483

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
36	34	(2)

Performance Results

Expected Result(s)	Performance Indicator(s)	Target(s)	Actual Results
Constructive engagement and support of public health stakeholders	Percent of population covered by functioning immunization registries	95 (by March 31, 2017)	70.6
Elimination status of measles, rubella, congenital rubella and polio in Canada is maintained through immunization against these diseases and surveillance of importations to Canada	% of WHO elimination/ eradication verification criteria met	95 (by March 31, 2015)	100

Performance Analysis and Lessons Learned

As a leader in guidance on vaccine use in Canada, the Agency provided public health professionals and immunization decision-makers with seven National Advisory Committee on Immunization statements on several vaccine-preventable diseases, including influenza, herpes zoster (shingles), pertussis (whooping cough), and meningococcal and pneumococcal disease. The Agency published updates to the online Canadian Immunization Guide[LVII] based on these statements, as well as other changes in evidence, which included measles and pertussis chapter updates. An interim statement on influenza was provided to P/T immunization program planning for the 2014–15 flu season. Immunization guidance for healthcare providers and other stakeholders informs evidence-based practices and the development of immunization programs and strategies, which are critical for effective prevention and control of vaccine-preventable diseases.

Along with the Canadian Public Health Association (CPHA), the Agency strengthened public immunization guidance by launching a free and innovative mobile application. ImmunizeCA[LVIII]

offers wireless tools to empower Canadians to manage their family's vaccinations and quickly access immunization information. The application provides local outbreak alerts, vaccination resources, as well as schedules and tools regarding children, adults and travellers.

The Agency enhanced its monitoring capabilities through the Measles and Rubella Surveillance (MARS) pilot project implemented in provinces representing approximately 25% of Canadians. Undertaken in British Colombia, Alberta, and Newfoundland and Labrador, the project continues to enable real-time, integrated investigation and surveillance of measles and rubella importations and outbreaks and supports Canada's ability to meet its national and international goals for eliminating these diseases. The Agency is currently assessing the findings of the pilot project.

During the 2013–14 influenza season, there was an increase in demand for the seasonal influenza vaccine. The total original demand was 10.3M doses, with an additional demand of approximately 500,000 doses identified in December 2013 and January 2014. The Agency, HC, and the Department of Public Works and Government Services Canada worked closely with P/Ts and vaccine manufacturers to address this increase in demand and to help successfully coordinate distribution of the necessary amount of vaccine to all P/Ts by February 2014.

Sub-Sub-Program 1.2.1.2: *Infectious and Communicable Diseases*

Description:

The Infectious and Communicable Diseases Program supports the prevention and control of infectious diseases by monitoring emerging and re-emerging infectious diseases which are identified by the Agency as leading causes of hospitalization and death in Canada, and by developing strategic approaches to reduce the likelihood of infection. The Program monitors and reports risk factors and trends associated with infectious diseases and works collaboratively with federal, provincial, territorial, and international partners to develop national approaches to manage infectious disease threats and decrease the transmission of communicable diseases and infections (such as hospital associated infections, sexually transmitted infections, HIV/AIDS, hepatitis B and C, tuberculosis, vaccine preventable diseases and other respiratory infectious diseases). The Program also seeks to reduce the risk and incidence of infections and injuries associated with blood transfusions and organ transplantation by providing knowledge products to federal, provincial, and territorial health care experts. This Program, informed by science, uses this knowledge to prevent infectious disease outbreaks and generate guidelines, education materials, frameworks and reports to guide decision making to support public health action. These activities inform national action plans and global responses to prevent and control infectious diseases, in accordance with the International Health Regulations. The Program uses funding from the following transfer payments: Federal Initiative to Address HIV and AIDS; Hep C Program.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
28,487,599	32,082,227	3,594,628

Note: Actual Spending was higher than Planned primarily due to the re-alignment of resources within the Agency according to needs and priorities.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
218	207	(11)

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Reduce the annual rate of active TB infections in key populations	The annual rate per 100,000 of active tuberculosis cases in key populations	3.6 (by March 31, 2015)	4.8
Up-to-date guidance information on prevention and control of infectious disease is available to provincial and territorial public health officials and other stakeholders to support policy and operational decisions	Percent of emerging and re-emerging infectious disease guidance information requiring update that is updated and disseminated annually	90 (by March 31, 2015)	95
Infectious disease surveillance information is available to support evidence based decision making	Percent of surveillance disease reports associated with key emerging and re-emerging infectious diseases that are updated and disseminated annually	90 (by March 31, 2015)	76.9

Performance Analysis and Lessons Learned

In 2014, the Minister of Health released Tuberculosis Prevention and Control in Canada: A Federal Framework for Action,[lix] a result of the Agency's collaboration with federal partners. The Framework articulates the role of stakeholder departments in reducing and addressing the factors contributing to rates of TB in Aboriginal peoples and foreign-born individuals, the

populations among which TB incidence remains relatively high.[21] As federal co-chair of the Pan Canadian Public Health Network's Communicable and Infectious Disease Steering Committee, the Agency is working toward implementing the Framework in a F/P/T forum, focusing on community mobilization pilot projects related to latent TB infections in at-risk Northern communities.

The Agency continued to support informed, evidence-based health care decision making among its stakeholders through the dissemination of 10 key surveillance reports and guidance documents, including Tuberculosis in Canada 2012 Pre-Release Surveillance Report.[LX] While the Agency is working towards its overall target for the update of surveillance reports for key emerging and re-emerging infectious diseases (due March, 2015), it prioritized the dissemination of reports based on timeliness and relevance of the surveillance information to best inform stakeholders. Updated standards and guidelines were added to the Agency's extensive online guidance[LXI] on blood-borne and sexually transmitted infections, *C. difficile*, TB, and antimicrobial-resistant pathogens. The ready availability of this information not only assists P/T public health officials and front-line healthcare workers in keeping abreast of public health practices, critical laboratory science and epidemiological developments, but also empowers Canadians to be active in the management of their own health.

The Agency launched a webinar series which promoted surveillance information, guidance, and knowledge products for TB, sexually transmitted and blood-borne infections, and AMR to more than 3,400 public health professionals. The Agency is leveraging modern tools to further expand the reach and timeliness of its evidence-based information products. This work also addresses recommendations from recent program evaluations such as the Evaluation of Community Associated Infections Prevention and Control Activities at the Public Health Agency of Canada[LXII] and the Evaluation of the Federal Initiative to Address HIV/AIDS in Canada (2008–09 to 2012–13).[LXIII]

Sub-Sub-Program 1.2.1.3: *Food-borne, Environmental and Zoonotic Infectious Diseases*

Description:

The Food-borne, Environmental and Zoonotic Infectious Diseases Program seeks to reduce the risk of food-borne, water-borne, environmental and zoonotic diseases in Canada which have the potential to adversely impact the health of Canada's population. By examining the interrelationship between the environment and human health, the Program develops and disseminates measures to address the risks associated with infectious disease threats such as

[21] The higher rates of active TB that persist among these population groups continued to drive the overall disease rate above the target, despite a decrease in the disease amongst the general population.

salmonella, *E.coli* 0157, West Nile virus, Legionella, and Listeria, including emerging antimicrobial resistance. The Program undertakes national surveillance of zoonotic diseases, targeted research projects with the aim of reducing infectious disease emergence, manages Canada's national and international response to food- and water-borne disease outbreaks; and addresses the risk associated with rising global population mobility through enhancing evidence-based information. The Program works with federal, provincial, territorial, and regional stakeholders as well as international public health organizations to address emerging global food-borne, water-borne, environmental and zoonotic infectious diseases, in keeping with Canada's obligations under the International Health Regulations.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
13,919,936	13,228,369	(691,567)

Note: The variance between Planned and Actual Spending was attributed to delays in staffing and in completing contracting processes.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
87	82	(5)

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Evidence of knowledge uptake of food safety surveillance information	Percent of surveillance information uptake by stakeholders	90 (by March 31, 2015)	89
Multi-jurisdictional food-borne and zoonotic illness outbreaks are detected and responded to in a timely manner	Percent of significant multi-jurisdictional clusters that are assessed for further investigation within 24 hours of notification	90 (by March 31, 2015)	87.5
Public access to information on Travel Health via social media	Number of referrals from social media to the travel health section of the Web site	12,000 (by March 31, 2015)	18,000

Performance Analysis and Lessons Learned

Under the Healthy and Safe Food for Canadians Framework,[LXIV] the Agency continued to strengthen the government's ability to prevent and respond to food-borne illness outbreaks

through enhanced surveillance. This included the expansion of the multi-partner FoodNet Canada[LXV] surveillance approach, and enhanced coordination and capacity to respond to multi-jurisdictional outbreaks through the development of tools, delivering training to partners and fostering targeted research on Canadians' food consumption. Enhancements to the Outbreak Central Collaboration Centre, a web-based communications tool using the Agency's Canadian Network for Public Health Intelligence,[LXVI] improved a key mechanism for the coordination of information-sharing between partners during an outbreak investigation.

The Agency provided 59 reports and 21 other publications to stakeholders to support the early detection of and response to food-borne illness, and to help combat the resistance of these illnesses to antibiotics in humans.

The Agency continued to enhance data on the health of travellers and travel-related diseases imported into Canada, and provided health care professionals and Canadians with up-to-date, complete, and easily-accessible information on travel health and safety. The Agency and the Department of Foreign Affairs, Trade and Development collaborated to establish a mechanism for integrating country-specific travel health information on the Travel.gc.ca[LXVII] portal, where Canadians can register to receive targeted messages while travelling. Information accessibility was promoted through a social media campaign that successfully increased traffic to the website.

In 2013–14, the Agency assessed 40 significant, multi-jurisdictional clusters of food-borne and zoonotic illness – indicators of potential outbreaks – for further investigation. The Agency assessed nearly 88% (35) of these clusters within 24 hours of being notified. This improvement in performance over 2012–13 (when 78% of clusters were assessed within 24 hours) is attributed to recent enhancements to the monitoring and assessment process, which is also expected to contribute to further improvement.

In addition, the 2013 Fall Report of the Auditor General of Canada,[LXVIII] assessed Canada's food safety recall system and found that the Agency adequately supported Canadian Food Inspection Agency (CFIA) investigations by providing timely information such as the number of people who have fallen ill and the food they consumed.

Sub-Program 1.2.2: *Conditions for Healthy Living*

Description:

The Conditions for Healthy Living Program supports improved health outcomes for Canada's population throughout life by promoting positive mental, social, and physical development, and by enabling the development of healthy communities. Population-wide health promotion efforts that respond to the needs of vulnerable and at-risk populations have been shown to improve health outcomes, especially in circumstances where poor social, physical or economic living conditions exist. The Program contributes to early childhood development, sustains healthy living conditions into youth and adolescence and builds individual and community capacity to support healthy transitions into later life. In collaboration with provinces, territories,

stakeholders, and individuals directly affected by a condition or disease, the Program advances priorities and initiatives to promote health and well-being. It also develops, tests, and implements evidence-based interventions and initiatives that can help those facing socially challenging circumstances (e.g., family violence, poor mental health, injuries, communicable infections, and social isolation). Finally, the Program provides exchanges evidence-based information for public health policies, practices and programs, and helps to build community public health capacity.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
201,147,034	198,855,408	(2,291,626)

Note: Actual Spending was less than Planned due to a transfer of authorities to HC for the Northern Wellness Approach.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
358	339	(19)

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Programs, policies and practices to promote health and reduce health inequalities are informed by evidence	Level of usage of science and intervention research evidence in public health policies, practices, programs by key stakeholders	70 (by March 31, 2015)	72
Communities have the capacity to respond to health inequalities of targeted populations	Percent of funded community organizations that leverage multisectoral collaborations to support at risk populations	70 (by March 31, 2015)	90[22]
	Percent of funded community organizations that have leveraged funds from other sources	50 (by March 31, 2015)	58[23]

[22] This indicator measures the percentage of funded community organizations receiving children's programs or *Innovation Strategy* funding for community projects that report having more than three types of partner organizations. Of the 753 funding recipients surveyed, 678 (90%) have been successful at developing collaborations.

[23] This indicator measures the percentage of funded community organizations that leverage funds from sources other than children's programs or Innovation Strategy (i.e. federal government funding other than the Agency, P/T and regional government funding, private sector). Of the 744 funding recipients surveyed, 431 (58%) have been successful in leveraging funds from other sources.

Performance Analysis and Lessons Learned

The Agency continued to produce science and evidence-based products to support communities' capacity to respond to the health inequalities of targeted populations. The most recent results of a survey showed that 72% of stakeholders reported that they have used or intended to use the Agency's science and intervention research evidence. As well, 90% of funded community organizations successfully developed collaborations with partners such as schools, health organizations, Aboriginal organizations, libraries, and food/clothing banks. In addition, 58% of funded community organizations were successful in leveraging funding from other sources, including P/Ts, municipal governments, not-for-profit, and community organizations.

The Agency continued to conduct mental illness surveillance and began to develop a positive mental health indicator framework to enable data collection on indicators such as social support and resilience. Work also continued on intentional injuries (e.g., suicide) and child maltreatment. A survey conducted on the *Canadian Incidence Study of Reported Child Abuse and Neglect 2008* found 80% of key stakeholders cited the data in their own work and more than half stated that the report findings had influenced program development and policy decisions.

The Agency took steps to improve public health capacity in the North, primarily through the establishment of the Iqaluit office. Agency employees on assignment in Iqaluit provided public health support and advice on several issues based on capacity needs in the territories, including maternal and child health, breastfeeding, oral health promotion, population health indicators, emergency preparedness and response, and TB.

The Evaluation of the Fetal Alcohol Spectrum Disorder (FASD) Initiative 2008-2009 and 2012-2013[LXIX] found there is a continuing need for the initiative, and that progress has been made toward achieving planned outcomes. Stakeholders are engaged and are responding to FASD priorities. Key evidence-based products were developed to fill knowledge gaps. There was limited evidence as to how widespread the use of these products was; however, the Agency is developing an FASD knowledge translation and exchange plan to enhance the use of these products in the development of policies and practices.

Sub-Sub-Program 1.2.2.1: *Healthy Child Development*

Description:

The Healthy Child Development Program promotes improvement of maternal and child health outcomes, and encourages positive health and development throughout the stages of infancy and childhood. Current research demonstrates that building resilience, developing empathy, exposing children to healthy eating practices and promoting breastfeeding can substantially compensate for adverse socio-economic conditions throughout their life. Through social science research, population health and community-based interventions, the Program works to promote positive physical, social and cognitive development, and reduce health inequalities in order to set a positive trajectory for sustained health throughout the life course. The Program engages key stakeholders to identify and address shared priorities related to healthy childhood and adolescent development, including fetal alcohol spectrum disorder, maternal and infant health, positive

parenting practices, and health status in Aboriginal and Northern communities. It supports interventions to assist pregnant women, children, adolescents and families who face circumstances such as low socio-economic status, family violence, poor mental health, and isolation. As well, it facilitates knowledge development and exchange of practice guidelines, frameworks for action, training, tools and supports which benefit the Canadian population, their families, other jurisdictions, national non-governmental organizations, and public health practitioners. The Program uses funding from the following transfer payments: Aboriginal Head Start in Urban and Northern Communities, Canadian Prenatal Nutrition Program, Community Action Program for Children, Fetal Alcohol Spectrum Disorder (FASD), and Joint Consortium for School Health.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
136,695,665	137,021,270	325,605

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
159	150	(9)

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Participation in PHAC funded interventions is positively associated with protective factors for healthy child development	Percent change in school readiness for Aboriginal participants in funded interventions relative to an Aboriginal population of non-participants	15 (by March 31, 2018)	19
	Percent of participants reporting positive parental-child interaction in funded interventions relative to a population of non-participants with comparable socio-demographic characteristics	58.9 (by March 31, 2018)	58.9

Performance Analysis and Lessons Learned

The Agency continued to deliver and fund programs that support healthy physical, social, and mental development in children to set a positive way forward so children may maintain good health throughout their lives. Children enrolled in the Aboriginal Head Start in Urban and

Northern Communities (AHSUNC) program for nine months showed a 19% improvement in school readiness skills. AHSUNC has had a measurable, positive effect on participants' language, social, motor and academic skills, and length of time in the program correlates positively to higher school readiness scores.

To reach more children and families in Nunavut, the Agency provided over $1M through the AHSUNC National Strategic Fund for two projects to build the capacity of Early Childhood Education (ECE) workers and to expand the availability of preschool programs for children ages three to five years of age. One project trained 103 adults in ECE, 82 adults gained credits for an ECE Certificate, and 56 childcare workers received ECE First Aid and Infant Cardiopulmonary Resuscitation certification.

As well, participants with high exposure to the Agency's Community Action Program for Children had significantly better positive "parental child interaction" scores compared to those with very low exposure to the program.[24] Through the *Health Portfolio Northern Wellness Contribution Agreement*, the Agency initiated a two-year, $1.9M partnership with HC and the Government of Nunavut on a project to improve the oral health of children from infancy to age seven.[LXX] As of March 2014, Community Oral Health Coordinator positions were established in 22 of the 25 communities to carry out oral health promotion and prevention activities. Dental teams have seen approximately 1,500 of the 5,000 children eligible to participate.

The Agency also invested $3M to enhance best practices and community action to address family violence, including the national adaptation of the Mother's Mental Health Toolkit[25] [LXXI] to enhance information given to community-based service providers regarding maternal mental health and how to support mothers experiencing a mental health problem. The Toolkit was disseminated to over 700 project sites, and more than 1,000 staff members were trained, including intensive training to sustain the Toolkit beyond the project timeline.

Sub-Sub-Program 1.2.2.2: *Healthy Communities*

Description:

The Healthy Communities Program aims to improve the community capacity to contribute to better health outcomes for Canada's population, including those who are vulnerable and at-risk. Evidence demonstrates that supportive social and physical community environments can have a positive impact on health status through the life course. Certain populations such as seniors, new Canadians, Aboriginal Peoples or those living with a communicable or infectious disease, are more likely to experience health challenges that can be prevented or mitigated in a community context. By engaging federal departments, other levels of government and stakeholders, the Program implements shared priorities and health promotion initiatives. The Program develops, adapts and implements promising, innovative population health and community-based initiatives and interventions that equip communities to support the population including those affected by a communicable disease in living the healthiest, most productive lives possible. The Program

[24] As assessed in a comparative analysis with a matched National Longitudinal Survey of Children and Youth sub-sample.
[25] The Agency collaborated on this project with the Izaak Walton Killam Health Centre affiliated with Dalhousie University.

facilitates the exchange and uptake of evidence-based information to inform decision making for policy and programs and improve public health outcomes within communities. The Program uses funding from the following transfer payments: Federal Initiative to Address HIV/AIDS, Innovation Strategy, Canadian HIV Vaccine Initiative and Hepatitis C Prevention, Support and Research Program.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
64,451,369	61,834,138	(2,617,231)

Note: Actual Spending was less than Planned due to a transfer of authorities to HC for the Northern Wellness Approach as well as delays in staffing and completing contracting processes.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
199	189	(10)

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Health promotion, policies and practices for supportive community environments are in place	Number of provinces and territories participating in Age Friendly Communities	10 (by March 31, 2015)	10
New Strategic Partnerships to promote health, prevent and control infections, and address barriers to care, treatment and support, are in place across Canada	% of programming funded through Strategic Partnerships	50 (by March 31, 2018)	Not available[26]

Performance Analysis and Lessons Learned

The Agency continued to deliver programs that build healthy and supportive community environments in areas of seniors and aging, mental health, family violence and suicide prevention. To help Canada's seniors lead healthy and active lives and to support community connectedness and seniors' continuing contributions to society, the Agency successfully

[26] Data not available. The Agency is currently exploring new models to support more effective and streamlined delivery of related funding programs.

facilitated the adoption of the Age Friendly Communities[LXXII] initiative in all provinces[27] and completed the Seniors' Falls in Canada: Second Report,[LXXIII] which provides current facts on the nature and severity of falls among Canadian seniors.

To advance suicide prevention efforts in Canada, the Agency engaged P/Ts, other federal government departments, non-governmental organizations, the general public, and others in consultations on a *Federal Framework for Suicide Prevention* through a variety of mechanisms including webinars, bilateral meetings, and an on-line survey. Preliminary results showed support for federal attention on suicide prevention and that Canadians consider suicide an important public health issue requiring action.

The Agency also partnered with the Canadian Institutes of Health Research to launch a project under the Arctic Council[LXXIV] to improve the understanding of resilience and positive mental health in children and youth in the North, entitled The Evidence-Base for Promoting Mental Wellness and Resilience to Address Suicide in Circumpolar Communities.[LXXV]

The Agency provided guideline development expertise, research advice, and support to the Canadian Task Force on Preventive Health Care[LXXVI] to develop a screening guideline to help primary care practitioners screen for depression in adults.

The Agency launched a transformation of its communicable and infectious disease grants and contributions program structure to help the Agency and its recipient organizations to better demonstrate effectiveness and accountability. Recognizing the significant parallels between associated population risk factors, the Agency broadened the scope of its funding programs for the prevention and control of HIV/AIDS[LXXVII] to include Hepatitis C.

Sub-Program 1.2.3: Chronic (non-communicable) Disease and Injury Prevention

Description:

The Chronic (non-communicable) Disease and Injury Prevention Program mobilizes and supports governmental and non-governmental organizations at national, provincial/territorial and local levels, and collaborates with international/national multi-sectoral stakeholders in designing, evaluating and identifying best practices, with the goal that policies and programs support healthy living, decrease chronic disease rates and reduce the impact of these diseases on Canada's population. This Program tracks injuries, chronic diseases, their risk factors and related inequalities, analyses the risks to public health, and determines priorities for action. It also identifies what works in chronic disease prevention and mitigation, according to scientific criteria, and disseminates these approaches widely to increase the use of effective interventions. Finally, it facilitates collaboration among stakeholders to increase the efficiency and

[27] Efforts to engage the territories at this time are not realistic given their demographics and current priorities focusing on children and youth.

effectiveness of chronic disease prevention and mitigation. The Program uses funding from the following transfer payments: Integrated Strategy for Healthy Living and Chronic Disease (Cancer, Diabetes, Cardiovascular Disease, Surveillance for Chronic Disease, Healthy Living, and Observatory of Best Practices), Canadian Breast Cancer Initiative, Federal Tobacco Control Strategy, and Promoting Access to Automated External Defibrillators in Recreational Hockey Arenas Initiative.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
60,389,625	53,389,941	(6,999,684)

Note: Actual Spending was less than Planned primarily due to the transfer of authorities to HC for the Health Portfolio Northern Wellness Approach contribution agreements. In addition, funding for contribution agreements that were delayed, was reallocated to other program priorities within Healthy Child Development program.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
198	188	(10)

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Chronic disease prevention priorities for Canada are identified and advanced	Percent of key stakeholders who agree that chronic disease and injury priorities have been advanced through collaboration with PHAC	70 (by March 31, 2015)	76[28]
Chronic disease prevention practice, programs and policies for Canadians are informed by evidence	Level of usage of evidence in chronic disease and injury policies and programs by key stakeholders	7[29] (by March 31, 2015)	7.2[30]

[28] As originally reported in the 2012–13 DPR, of the 41 key neurological stakeholders surveyed, 31 (76%) rated the success of the collaborative approach as excellent or good. Data collection for this indicator is ongoing, with a planned reporting date of March 2015.

[29] The target for this indicator is based on a 1-10 rating scale with 1 being "low" and 10 being a "high" level of usage of evidence. The Agency is targeting an average rating across key stakeholders of 7 or higher.

[30] As originally reported in the 2012–13 DPR, of the 329 stakeholders surveyed, 236 (7.2 or 72%) have used the Agency's products or intend to use them in the future. Data collection for this indicator is ongoing, with a planned reporting date of March 2015.

	Percent of key stakeholders using best and promising practices / interventions to inform chronic disease and injury prevention practice	70 (by March 31, 2015)	Data will be available in 2014–15

Performance Analysis and Lessons Learned

Collaboration continued with stakeholders on the *National Population Study of Neurological Conditions*.[LXXVIII] The completion of all 17 research projects under the Study— including subjects such as dementia, Alzheimer's disease, and multiple sclerosis—enabled the Agency and its partners to create a report on the findings. Key stakeholders reported this as a landmark study, both in terms of the degree of collaboration and the amount of insight generated.

Development continued on the *National Autism Surveillance System*[LXXIX] in collaboration with stakeholders, which included completing an environmental scan of P/T data sources and reporting on the feasibility of data collection. Stakeholders responded that the Agency and partners are progressing toward the long-term objective of developing and implementing the System. The Agency also funded a *National Needs Assessment Survey For Families, Adults with Autism Spectrum Disorder and Professionals*[LXXX] to canvass the views of Canadians to support future surveillance efforts.

A real-time secure surveillance system was launched to identify emerging hazards, injury trends, illnesses and deaths related to consumer products and other risk factors. This system enables the Agency and participating hospitals to identify injury risks and respond appropriately in a timely manner. Several articles were also published on injury risk assessment in the *Chronic Disease and Injuries in Canada*[LXXXI] journal on topics such as bicycle helmets,[LXXXII] unintentional injuries in areas with a high percentage of Aboriginal-identity residents,[LXXXIII] fall-related mortality in older adults,[LXXXIV] and traumatic spinal cord injuries.[LXXXV] Further, 75% of key stakeholders reported using, or intending to use, surveillance and prevention information from the *Injury in Review* report in their professional activities.

The Evaluation of the *Active and Safe* Initiative[LXXXVI] found enhanced community capacity to develop injury prevention products and an increased understanding of how to prevent sport and recreation-related injuries. More than 50% of the funded projects developed injury prevention activities and programs, including the *Open Water Wisdom Campaign*[LXXXVII] and the accredited *Making Head Way in Sports*[LXXXVIII] concussion-prevention training modules for coaches.

Program 1.3: *Health Security*

Description:

The Health Security Program takes an all-hazards approach to the health security of Canada's population, which provides the Government of Canada with the ability to prepare for and respond to public health issues and events. This Program seeks to bolster the resiliency of the

population and communities, thereby enhancing the ability to cope and respond. To accomplish this, its main methods of intervention include actions taken through partnerships with key jurisdictions and international partners. These actions are carried out through the implementation and maintenance of *International Health Regulations* and through the administration and enforcement of legislation, including the *Emergency Management Act*, the *Quarantine Act*, the *Human Pathogens and Toxins Act*, the *Health of Animals Act*, and the *Human Pathogens Importation Regulations*.

Budgetary Financial Resources (dollars)

2013–14 Main Estimates	2013–14 Planned Spending	2013–14 Total Authorities Available for Use	2013–14 Actual Spending (authorities used)	2013–14 Difference (actual minus planned)
47,709,580	48,954,953	77,673,470	73,097,007	24,142.054

Note: Actual Spending was higher than Planned due to the pandemic vaccine fill line project; supplementary purchases of antivirals made for the National Emergency Strategic Stockpile (NESS); and additional expenditures for two programs that were transferred from HC and the CFIA.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
231	269	38

Note: Actual FTEs were higher than Planned due to the transfer of resources from HC and the CFIA to the Agency as a result of government-wide re-organization, and the re-alignment of resources within the Agency according to needs and priorities.

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Canada has the partnerships and regulatory frameworks to prevent, prepare for and respond to threats to public health	Percent of partnerships with key jurisdictions and international partners in place to prepare for and respond to public health issues and events	100 (by March 31, 2015)	100
	Percent of Government of Canada's health emergency and regulatory programs implemented in accordance with the *Emergency Management Act*, the *Quarantine Act*, the *Human Pathogens and Toxins Act* and the *Human Pathogens Importation Regulations*	100 (by December 31, 2015)	100

Performance Analysis and Lessons Learned

Collaborative activities with other government departments, P/Ts, and international partners are important to advancing Canada's health security agenda, and strengthening Canada's capacities to detect, assess, notify, and respond to public health risks and emergencies of national and international significance. For example, through Canada-United States (U.S.) cooperation under the *Beyond the Border Health Security Action Plan*, the Agency successfully collaborated with Public Safety Canada and the U.S. Department of Health and Human Services, identifying the challenges and potential considerations for improving the exchange of emergency response resources. A plan for Canada-U.S. cooperation to advance laboratory biosafety, biosecurity, and pathogen control based on partnerships was also developed. Additionally, through the *Global Health Security Action Group's Early Alerting and Reporting Platform*, the Agency monitored public health risks using open source, unclassified intelligence on emerging chemical, biological, radiological, and nuclear events.

The result of successive rounds of stakeholder engagement was the recognition that a *National Pathogen Oversight Framework* can only be achieved through a sound understanding of stakeholders' varied needs and drivers. The development of sector-specific strategies, with engagement at multiple levels, enabled the Agency to better understand *Human Pathogens and Toxins Act* (HPTA) implications. These stakeholder approaches raised the importance of biosafety awareness, promoted HPTA compliance, and helped identify best practices. This knowledge drove the development of the risk-based Human Pathogens and Toxins Regulatory Proposal.

Sub-Program 1.3.1: *Emergency Preparedness and Response*

Description:

The Emergency Preparedness and Response Program is the central coordinating point among federal, provincial, territorial and non-governmental public health partners. The Program is also responsible for strengthening the nation's capacity to help prevent, mitigate, prepare and respond to public health emergencies. In order to meet these goals, the Program's interventions include emergency preparedness, emergency planning, training and exercises, ongoing situational awareness and risk assessment, maintenance of a Health Portfolio Operations Centre, coordination of inter-jurisdictional mutual aid, deployment of surge capacity to provinces and territories, and deployment of Microbiological Emergency Response Teams and associated mobile laboratories. The Program seeks to protect all persons living in Canada and provides surge capacity to provinces and territories and fulfills Canada's international obligations for events, such as infectious disease, pandemic influenza and bioterrorism. In addition, it coordinates response to national or man-made disasters and preparedness for mass gatherings and high profile events. The Program supports the continued implementation of the Emergency Management Act and *International Health Regulations*, and it also makes a significant contribution to the Beyond the Border (BTB) initiatives and to the North American Plan for Animal and Pandemic Influenza.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
35,638,132	57,649,035	22,010,903

Note: Actual Spending was higher than Planned primarily due to additional spending for the pandemic vaccine fill line project; replenishment of the NAS; and supplementary purchases of antivirals for the NESS.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
145	154	9

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Canada has the capacity to prevent, mitigate, prepare and respond to public health emergencies including infectious disease	Percent of all-hazards and disease specific plans and procedures developed, maintained and kept current at all times	100 (by March 31, 2015)	89
	Percent of inter-jurisdictional mutual aid/federal assistance requests coordinated for domestic and international response and resource sharing within negotiated timelines	100 (by March 31, 2015)	100
	Percent of required health portfolio capabilities ready to respond to events/emergencies on 24/7 basis	100 (by March 31, 2015)	100

Performance Analysis and Lessons Learned

All-hazards and disease plans and procedures are essential tools to inform emergency preparedness and response decision making, coordination, and collaboration. The Agency updated five plans during the year including the *Health Portfolio Emergency Response Plan*. While significant work was undertaken to draft the *Pan Canadian All Hazards Health Emergency Response Protocols*, this work was not completed as planned. However, stakeholder review and approval is anticipated in 2014–15.

The Agency participated in multiple exercises to test Canada's emergency management plans. For example, the Agency participated in Exercise Nanook, an emergency exercise jointly led by the Department of National Defence and the Yukon government. Participation in this exercise enabled the Agency to test and strengthen key incident management systems and prepare for future possible emergencies in the North.

In response to the Alberta floods of 2013, the Agency coordinated a response request for mutual assistance through the F/P/T *Operational Framework for Mutual Aid Requests*. Eighty-eight Environmental Health Officers from across Canada were identified for deployment within 24 hours, enabling Alberta to enter into bilateral agreements with its partners British Columbia and Saskatchewan.

The Agency developed a policy frame and an optimization plan to take a more strategic approach to managing the NESS. In addition, the Agency provided training to P/T Health Authorities on the set up of the NESS Mini-Clinics, which have been designed to meet current standards for emergency clinical care.

Health Portfolio staff readiness to respond to events/emergencies on a 24/7 basis was achieved. Through a mix of preparatory training, exercise opportunities, and on-the-job training during events, the Health Portfolio maintained a roster of available staff to operate within an Incident Management System during an emergency. The Agency maintained capacity for 24/7 situational awareness. For example, the Agency effectively and rapidly responded to the confirmation of the first case of H5N1 in North America.

Sub-Program 1.3.2: *Border Health Security*

Description:

The Border Health Program builds and maintains the health security of the Canadian population by implementing public health measures across borders. The Program includes communicable disease control and environmental health services activities to help maintain public health and provide information to international travellers. This Program administers and enforces the *Quarantine Act* and elements of the *Department of Health Act*, to reduce or delay the introduction of communicable diseases into or from Canada. The issuance of Ship Sanitation Certificates to international vessels, the implementation of passenger terminal and passenger transportation inspection programs (conveyances), and responding to passenger conveyance gastrointestinal disease outbreaks also help to prevent the introduction and spread of communicable diseases. The Border Health Security Program promotes coordinated border health measures by creating linkages between key border departments and agencies, including the Canadian Border Services Agency, Royal Canadian Mounted Police, and the Canadian Food Inspection Agency.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
2,750,566	5,336,659	2,586,093

Note: Actual Spending and FTEs were higher than Planned due to the transfer of the Travelling Public Program from HC to the Agency.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
31	51	20

Note: Actual FTEs were higher than Planned due to the transfer of the Travelling Public Program from HC to the Agency.

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Risks associated with import and export of communicable diseases into and out of Canada are mitigated and/or controlled	Percent of inspected passenger conveyances (ships, planes, trains) that meet federal guidelines	75 (by March 31, 2015)	88
	Percent of designated Canadian points of entry that maintain the IHR core capacities	100 (by March 31, 2015)	100

Performance Analysis and Lessons Learned

The Agency's Office of Border Health Services was created on April 1, 2013 by amalgamating the Agency's Quarantine Program with HC's Travelling Public Program. The integration of these programs helped the Agency create a stronger link with federal, provincial, local public health and international partners to enhance border health security and to prevent the introduction and spread of communicable diseases.

The Agency worked with air, water, and land public conveyance operators to complete 460 public health inspections and 14 investigations, including six investigations of gastrointestinal outbreaks on cruise ships. Assisting in the development of *Potable Water and Sanitation Management Plans*, appropriate systems were put in place by operators to provide a safe and healthy travelling environment for travellers, in compliance with federal inspection guidelines. When public health risks were identified, the Agency also worked with operators to mitigate them.

The Agency maintained public health capacity at all of Canada's IHR designated Points of Entry to communicate rapidly, provide a safe environment for travellers (e.g., food, water, and sanitary facilities), assess and care for ill travellers, and respond to public health events/emergencies. The Agency also issued 778 ship sanitation certificates as per IHR requirements, and collaborated with the Canadian Border Services Agency, airport authorities, emergency medical services, local health authorities, the WHO, and U.S. authorities to enable efficient notification and response to border health events/emergencies. Programming was available 24/7 to respond to enquiries and coordinate emergency responses when needed.

Sub-Program 1.3.3: *Biosecurity*

Description:

The Biosecurity Program is responsible for administration and enforcement activities related to the use and manipulation of human, terrestrial animal pathogens, and toxins. This Program has specific responsibility under the *Human Pathogens and Toxins Act* and the Human Pathogens Importation Regulations, and select sections of the *Health of Animals Act* to promote and enforce safe and secure biosafety practices and laboratory environments. The Program's main methods of intervention include the issuance of import permits, laboratory inspections, lab certification and verification, education through the provision of knowledge products and training, and compliance and enforcement activities. Researchers, industries, hospitals and laboratories that handle pathogens and toxins are provided with regulatory oversight—including laboratory certification, inspection, guidance and the issue of importation permits. This Program further contributes to the health security of the population by mitigating risks posed by pathogen misuse such as a deliberate release or the intentional production of bioterrorism agents.

Budgetary Financial Resources (dollars)

2013–14 Planned Spending	2013–14 Actual Spending	2013–14 Difference (actual minus planned)
10,566,255	10,111,313	(454,942)

Note: The variance is due to efficiencies gained through joint management of the Single Window project with HC.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
55	64	9

Note: Actual FTEs were higher than Planned due to the transfer of the Domestic Terrestrial Animal Pathogen Unit from CFIA to the Agency.

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Safe and secure biosafety practices and laboratory environments	Percent of federally registered laboratories working with moderate risk pathogens and toxins compliant with requirements	90 (by December 31, 2015)	100

	Percent of federally registered laboratories working with high risk pathogens and toxins compliant with requirements	80 (by March 31, 2015)	100
	Percent decrease of laboratory acquired infections[31]	0 (by December 31, 2021)	0

Performance Analysis and Lessons Learned

Since 2009, the Agency has engaged in a comprehensive and iterative consultation process with stakeholders on the development of the supporting programmatic and regulatory framework for the HPTA. Feedback from Phase III consultations, which sought input regarding proposed policy direction on key elements, was considered in the final design of the program elements and enabled the Agency to finalize the Human Pathogens and Toxins Regulatory Proposal in late 2013–14.

The Agency and the CFIA consolidated regulatory authorities to eliminate the duplication of regulatory and administrative requirements for the importation control of human and terrestrial animal pathogens.[32] Consolidation resulted in significant efficiency gains for regulated parties and a reduction in duplication of: 76% for import permits, 36% for compliance letters, and 21% for the participation of inspectors on inspections. A client survey confirmed that administrative efficiencies have been gained by providing a single window for client service delivery that regulated parties view as a positive change.

The Evaluation of the Biosecurity Program (2009–2014)[LXXXIX] found a continued need to address laboratory biosafety and biosecurity in Canada and that the objectives of the Program align well with Government of Canada and Agency roles and responsibilities. The evaluation also found that the Program successfully engaged its stakeholders, resulting in enhanced awareness and uptake of laboratory biosafety and biosecurity practices. In addition, the findings showed that the Program established operational practices that mitigated the administrative burden to regulated organizations and demonstrated excellence in regulatory administrative practices.

Under the existing regulatory regime, the Agency completed 13 audits of laboratories working with moderate-risk pathogens and toxins and a further 13 audits of laboratories working or intending to work, with high-risk pathogens and toxins. Minor issues were initially observed in all audited laboratories; however, corrective actions were completed within established timeframes resulting in a compliance rate of 100% for each segment. A co-operative approach between regulated parties and the Agency remains key to achieving compliance.

[31] Baseline or Average Annual Expected laboratory acquired infections is to be established following the initiation of prospective reporting at the end of 2015. A minimum of five consecutive years of data will be needed to establish an accurate baseline.

[32] Excluding emerging and foreign animal disease pathogens

Internal Services

Description:

Internal Services are groups of related activities and resources that are administered to support the needs of programs and other corporate obligations of an organization. These groups are: Management and Oversight Services; Communications Services; Legal Services; Human Resources Management Services; Financial Management Services; Information Management Services; Information Technology Services; Real Property Services; Materiel Services; Acquisition Services; and Other Administrative Services. Internal Services include only those activities and resources that apply across an organization and not to those provided specifically to a program.

Budgetary Financial Resources (dollars)

2013–14 Main Estimates	2013–14 Planned Spending	2013–14 Total Authorities Available for Use	2013–14 Actual Spending (authorities used)	2013–14 Difference (actual minus planned)
90,212,368	90,941,557	114,557,718	109,482,900	18,541,343

Note: Actual Spending was greater than Planned due to additional funding received from the operating budget carry forward, an increase in statutory revenue, and payments for paylist expenditures.

Human Resources (FTEs)

2013–14 Planned	2013–14 Actual	2013–14 Difference (actual minus planned)
615	274	(341)

Note: Actual FTEs were less than Planned due to the transfer of various programs to HC as part of the Health Portfolio Shared Services Partnership (PSSP).

Performance Analysis and Lessons Learned

One of the key lessons learned in the PSSP is that flexibility and regular engagement with clients and senior management were vital to adapting to changing needs as diverse requirements and expectations evolved. For example, a *Policy Harmonization Framework* was created to guide the development of common sets of internal service policies, and significant progress was made to develop and integrate harmonized policies, practices, and services. Efforts were also focussed on Information Management (IM) Readiness, including implementation of the IM Strategy and integration of harmonized IM policy instruments.

Responding to the government-wide priority, the Agency successfully developed and implemented an Employee Performance Management Program. Targets were met, including manager certification, training, and employee communications. As well, implementation of the

Agency's National Accommodation Strategy and planned office modernization projects was successfully completed.

Within the Health Portfolio, the Agency continued to align its communications activities and services to promote the health of Canadians and communicate vital information they need to protect their health.

The Agency continued to enhance transparency and engagement with Canadians and stakeholders through innovative communications tools and approaches. The Agency developed social marketing campaigns and initiatives to help raise awareness and knowledge of key health and safety topics. Campaigns were also developed to protect against illnesses such as Lyme disease and seasonal influenza. To reach Canadians in relevant ways, the Healthy Canadians social media campaign expanded its social media platforms to include Pinterest, Twitter, and YouTube; these activities were in addition to the Facebook page which has over 29,000 "likes". With the December 2013 launch of Canada.ca, all of the Agency's Web pages were made more accessible so that all Canadians can get the information they need online.

Section III: Supplementary Information

Financial Statements Highlights

Public Health Agency of Canada Condensed Statement of Operations and Agency Net Financial Position (unaudited) For the Year Ended March 31, 2014 (dollars)					
	2013–14 Planned Results	**2013–14 Actual**	**2012–13 Actual (Restated) ***	**Difference (2013–14 actual minus 2013–14 planned)**	**Difference (2013–14 actual minus 2012–13 actual)**
Total expenses	621,394,000	634,664,000	583,348,000	13,270,000	51,316,000
Total revenues	50,000	15,269,000	11,492,000	15,219,000	3,777,000
Net cost of operations before government funding and transfers	621,344,000	619,395,000	571,856,000	(1,949,000)	47,539,000
Agency net financial position	102,780,000	101,421,000	97,489,000	(1,359,000)	3,932,000

* Please refer to the Agency's 2013–14 Financial Statements for further details.

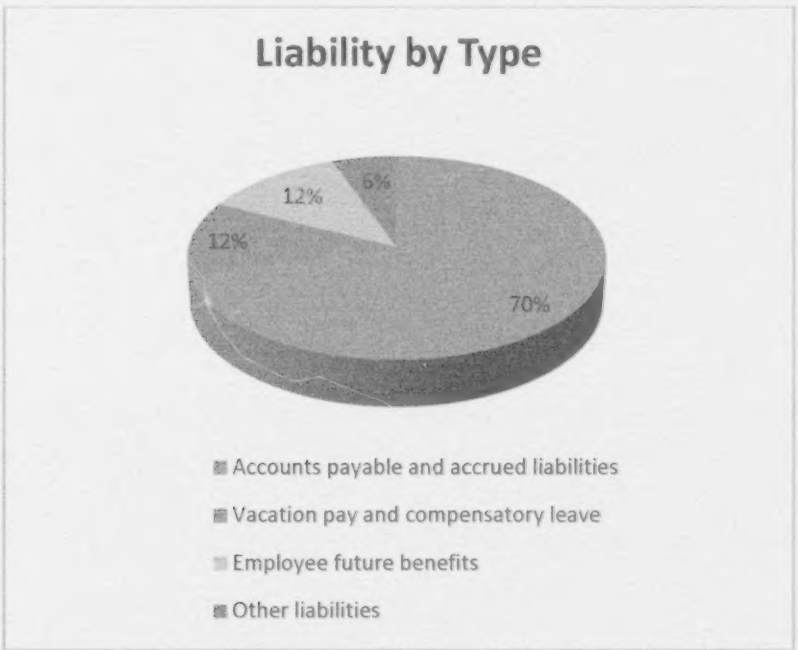
The $13.3M difference between Planned Results and Actual Expenses is primarily due to the receipt of in-year funding in Supplementary Estimates and the corresponding expenses for the installation of the influenza vaccine fill-line, replenishment of the National Antiviral Stockpile, the enhancement of the ability to prevent, detect and respond to food-borne illness outbreaks, and the spending of revenues for services provided to Health Canada (HC) under the Health Portfolio Shared Services Partnership (PSSP).

The $51.3M change between 2013–14 and 2012–13 Actual Expenses is primarily due to the adjustment (reduction) to the expenses for salaries and employee benefits in 2012–13 to more accurately reflect the actual expenses incurred for workforce adjustment, and the accumulation and liquidation of severance versus the estimate of these expenses made in 2011–12, plus an increase in expenses for professional and special services in 2013–14 primarily for the influenza vaccine fill-line and for services provided by HC under the SSP. This increase is partially offset by savings achieved through the implementation of business transformation initiatives and administrative efficiencies.

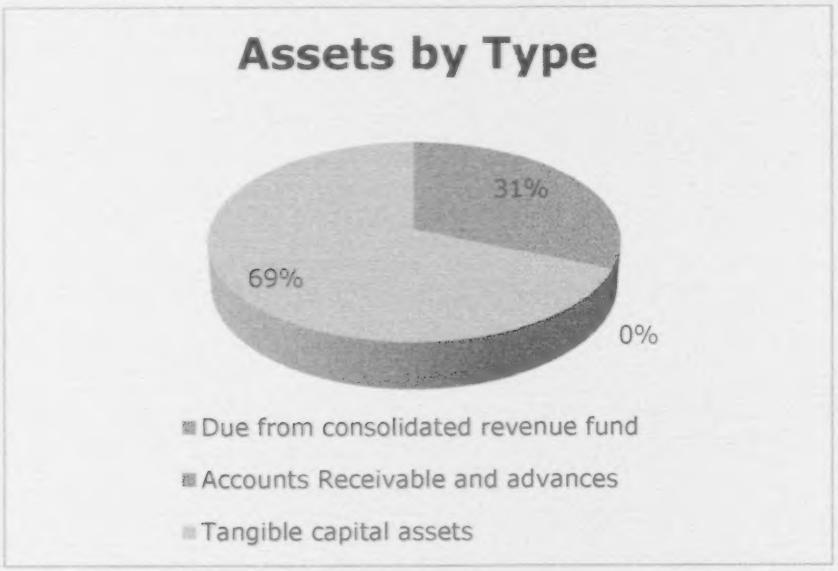
With respect to total revenues, the $15.2M difference between Planned Results and Actual was primarily due to the recognition of HC payments as revenues for Agency services provided to HC under the SSP.

Public Health Agency of Canada Condensed Statement of Financial Position (unaudited) As at March 31, 2014 (dollars)			
	2013–14	**2012–13 (Restated) ***	**Difference (2013–14 minus 2012–13)**
Total net liabilities	83,803,000	120,736,000	(36,933,000)
Total net financial assets	58,221,000	90,336,000	(32,115,000)
Departmental net debt	25,582,000	30,400,000	(4,818,000)
Total non-financial assets	127,003,000	127,889,000	(886,000)
Agency net financial position	101,421,000	97,489,000	3,932,000

* Please refer to the Agency's 2013–14 Financial Statements for further details.



Total liabilities were $83.8M, a decrease of 31% ($36.9M) over the previous year's total of $120.7M. The decrease was primarily due a reduction in the accounts payable (to external parties) and accrued liabilities (mostly for contributions payable at year-end). Accounts payable and accrued liabilities represented $59.1M (70%); vacation pay and compensatory leave represented $9.9M (12%); employee future benefits represented $10.1M (12%); and other liabilities represented $4.7M (6%) of total liabilities.



Total assets were $185.2M, a decrease of 15% ($32.9M) over the previous year's total of $218.2M. The decrease was primarily due to the reduced amount required from the consolidated revenue fund for liabilities. The "Due from the Consolidated Revenue Fund" represented $58.0M (31%) and tangible capital assets represented $127.0M (69%) of total assets.

Financial Statements

The Agency's 2013–14 Financial Statements[xc] are available online.

Supplementary Information Tables

The supplementary information tables listed in the *2013–14 Departmental Performance Report* can be found on the Agency's website.[xci]

- Departmental Sustainable Development Strategy;
- Details on Transfer Payment Programs;
- Horizontal Initiatives;
- Internal Audits and Evaluations;
- Response to Parliamentary Committees and External Audits; and
- Status Report on Projects Operating With Specific Treasury Board Approval.

Tax Expenditures and Evaluations

The tax system can be used to achieve public policy objectives through the application of special measures such as low tax rates, exemptions, deductions, deferrals and credits. The Department of Finance Canada publishes cost estimates and projections for these measures annually in the Tax Expenditures and Evaluations[xcii] publication. The tax measures presented in the *Tax Expenditures and Evaluations* publication are the sole responsibility of the Minister of Finance.

Section IV: Organizational Contact Information

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Appendix: Definitions

appropriation: Any authority of Parliament to pay money out of the Consolidated Revenue Fund.

budgetary expenditures: Include operating and capital expenditures; transfer payments to other levels of government, organizations or individuals; and payments to Crown corporations.

Departmental Performance Report: Reports on an appropriated organization's actual accomplishments against the plans, priorities and expected results set out in the corresponding Reports on Plans and Priorities. These reports are tabled in Parliament in the fall.

full-time equivalent: Is a measure of the extent to which an employee represents a full person-year charge against a departmental budget. Full-time equivalents are calculated as a ratio of assigned hours of work to scheduled hours of work. Scheduled hours of work are set out in collective agreements.

Government of Canada outcomes: A set of 16 high-level objectives defined for the government as a whole, grouped in four spending areas: economic affairs, social affairs, international affairs and government affairs.

Management, Resources and Results Structure: A comprehensive framework that consists of an organization's inventory of programs, resources, results, performance indicators and governance information. Programs and results are depicted in their hierarchical relationship to each other and to the Strategic Outcome(s) to which they contribute. The Management, Resources and Results Structure is developed from the Program Alignment Architecture.

non-budgetary expenditures: Include net outlays and receipts related to loans, investments and advances, which change the composition of the financial assets of the Government of Canada.

performance: What an organization did with its resources to achieve its results, how well those results compare to what the organization intended to achieve and how well lessons learned have been identified.

performance indicator: A qualitative or quantitative means of measuring an output or outcome, with the intention of gauging the performance of an organization, program, policy or initiative respecting expected results.

performance reporting: The process of communicating evidence-based performance information. Performance reporting supports decision making, accountability and transparency.

planned spending: For Reports on Plans and Priorities (RPPs) and Departmental Performance Reports (DPRs), planned spending refers to those amounts that receive Treasury Board approval by February 1. Therefore, planned spending may include amounts incremental to planned expenditures presented in the Main Estimates.

A department is expected to be aware of the authorities that it has sought and received. The determination of planned spending is a departmental responsibility, and departments must be able to defend the expenditure and accrual numbers presented in their RPPs and DPRs.

plans: The articulation of strategic choices, which provides information on how an organization intends to achieve its priorities and associated results. Generally a plan will explain the logic behind the strategies chosen and tend to focus on actions that lead up to the expected result.

priorities: Plans or projects that an organization has chosen to focus and report on during the planning period. Priorities represent the things that are most important or what must be done first to support the achievement of the desired Strategic Outcome(s).

program: A group of related resource inputs and activities that are managed to meet specific needs and to achieve intended results and that are treated as a budgetary unit.

results: An external consequence attributed, in part, to an organization, policy, program or initiative. Results are not within the control of a single organization, policy, program or initiative; instead they are within the area of the organization's influence.

Program Alignment Architecture: A structured inventory of an organization's programs depicting the hierarchical relationship between programs and the Strategic Outcome(s) to which they contribute.

Report on Plans and Priorities: Provides information on the plans and expected performance of appropriated organizations over a three-year period. These reports are tabled in Parliament each spring.

Strategic Outcome: A long-term and enduring benefit to Canadians that is linked to the organization's mandate, vision and core functions.

sunset program: A time-limited program that does not have an ongoing funding and policy authority. When the program is set to expire, a decision must be made whether to continue the program. In the case of a renewal, the decision specifies the scope, funding level and duration.

target: A measurable performance or success level that an organization, program or initiative plans to achieve within a specified time period. Targets can be either quantitative or qualitative.

whole-of-government framework: Maps the financial contributions of federal organizations receiving appropriations by aligning their programs to a set of 16 government-wide, high-level outcome areas, grouped under four spending areas.

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